

068289 OCT 13 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29810

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR						
C			HENRY			ACHENBACH			OCTOBER 5, 1987			5:20 AM			
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
MALE			CAUCASIAN			MAY 11 1891			96 YRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD			
NEW YORK			USA						MONTGOMERY						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
ROCKVILLE			SHADY GROVE ADVENTIST NURSING CTR			ACCOUNTANT			EBASCO						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			
			MARYLAND			MONTGOMERY			GAITHERSBURG			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e STREET ADDRESS									
UNOBTAINABLE			UNOBTAINABLE			19310 CLUB HOUSE ROAD/507									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS									
YES			WWI			089-09-9459			ADELAIDE ACHENBACH GAITHERSBURG, MD 20879						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STOMACH CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			6 MONTHS		
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
CONGESTIVE HEART FAILURE; BONE MARROW FAILURE															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) XXXXXX attended the deceased from MAY 1987 to OCTOBER 5 1987 that (I) XX lost saw the deceased alive on OCTOBER 2 1987, and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) XX did XXXXXX view the body after death.										22c DATE SIGNED			10/8/87		
22b SIGNATURE										DEGREE					
CHERYL WINCHELL, MD										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS									
CHERYL WINCHELL, MD						19241 MONTGOMERY VILLAGE AVE (20879)									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE						
BURIAL			10/7/1987			FAIRFAX MEMORIAL PARK			FAIRFAX VIRGINIA						
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE RECEIVED BY REGISTRY									
DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA 22314						OCT 09 1987									

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP
DHMH - 16 60M 7/73
(VRA 15 (4))

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

108100 2050 91



108100

068156 OCT

-9-87
DATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29817

1 DECEASED NAME (TYPE OR PRINT) Eloise Thresa Addington			2a DATE OF DEATH MONTH DAY YEAR 10 / 7 / 87			2b HOUR 8:45 AM				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 1 22 40		6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Albany, New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b KIND OF BUSINESS OR INDUSTRY Electronics		
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Germantown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Raymond P. Keiflin			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Cowles			13e STREET ADDRESS / ZIP CODE 20300 Frederick Rd. #51				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-50-2030		17 INFORMANT Carol Cropper				12307 ADDRESS Molly Berry Rd. Upper Marlboro, Md.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ESOPHAGEAL CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 MONTHS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 c										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P M 19			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P M 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (the hospital) attended the deceased from <u>SEPTEMBER 29</u> 19 <u>87</u> to <u>OCTOBER 7</u> 19 <u>87</u> that (I) lost saw the deceased alive on <u>OCTOBER 6</u> 19 <u>87</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.										
22b SIGNATURE George Bolen						DEGREE M.D.		22c DATE SIGNED 10/7/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BOLEN, M.D.						22e ADDRESS 711 MEDICAL CENTER DRIVE, #308 ROCKVILLE MD. 20850				
23a BURIAL, CREMATION, REMOVAL (USUAL PRACTICE) Burial			23b DATE Oct 10, 1987		23c NAME OF CEMETERY OR CREMATORY National Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax Va			
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. Clinton, Maryland						25a DATE REC'D. BY REGISTRAR OCT - 8 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit form. The glasses remove air bubbles. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B should only if any other traumatic event, the medical examiner must be notified.

BP

TO: [illegible]
FROM: [illegible]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29818

FOR
STATE
REGISTRAR

70863' NOV -587

1 DECEASED NAME (TYPE OR PRINT) ELLEN HANNA PEDRICK / LCORN		2a DATE KNOWN OF ESTI- DEATH MATED 10 26 1987		2b HOUR 11:00
3 SEX FEMALE	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 1-1-03	6 AGE (IN YEARS) (LAST BIRTHDAY) 84 YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Gaithersburg	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 101 Odenhal Ave., #905	12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE JOHN HOPKIN Applied Physics Lab.		
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 101 Odenhal Ave., #905 20877
14 FATHER'S NAME FIRST MIDDLE LAST William Hanna, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Pedrick		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-05-2980		17 INFORMANT 19733 Meredith Dr., Derwood, Raymond W. Alcorn, Maryland 20855
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE John Tamber		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 10-28-87
EXAMINER'S NAME (TYPE OR PRINT) John Tamber		ADDRESS 5218 Wisconsin Ave		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 11-02-87	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland	
24 NAME OF FUNERAL HOME (TYPE OR PRINT) FRANCIS GASCH'S SONS FUNERAL HOME, P.A.		25a DATE REC'D. BY REGISTRAR NOV 4 1987		
24 ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland		25b REGISTRAR'S SIGNATURE Julia Davidson-Rudner		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, AND 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP
DHMH-17
(VR A15 ME (5))

70003 NOV-201

ELLEN HANNA ALCOEN

FRANK WILTS 1-102 24

MONTGOMERY

FRANK WILTS 1-102 24

FRANK WILTS 1-102 24

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68139 OCT -9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin L. Allen			2a. DATE OF DEATH MONTH DAY YEAR 10-6-87		2b. HOUR 0440 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 30 1934		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	IF UNDER 1 YEAR MONTHS DAYS HRS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Gaitherburg Lumber	
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James p. Allen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gracie Wetzel		16. STREET ADDRESS / ZIP CODE 106 Contour Road 21771	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-4668	17. INFORMANT Margie Allen Contour Rd, Mt. Airy, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC HYPERNEPHROMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/1/87-10/6/87
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 3, 1987, to OCTOBER 6, 1987, that (I) (we) last saw the deceased alive on OCTOBER 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE HERBERT M. JUARBE		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT M. JUARBE		22e. ADDRESS 15225 SHADY GROVE RD. #105, ROCKVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE October 9,	23c. NAME OF CEMETERY OR CREMATORY Catlett Methodist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fauquier Virginia	
24. FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md. 20879		1987 ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 8 1987	25b. REGISTRAR'S SIGNATURE Julia Darden-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 5, and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, (a) medical examination by the medical examiner is required.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

069120 OCT 20 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ANASTASIO			2a DATE OF DEATH MONTH DAY YEAR 10 9 87			2b HOUR 10:27 A M				
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR AUGUST 12, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b CITIZEN OF WHAT COUNTRY? ITALY		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STONE MASON		12b KIND OF BUSINESS OR INDUSTRY QUARRY		
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN KENSINGTON		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4404 COLCHESTER DRIVE 20895	
14 FATHER'S NAME FIRST MIDDLE LAST ALIBRANDO AMBROGI				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTERE ROSSI						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO 220-34-3260		17 INFORMANT ADDRESS BRUNA AMBROGI WIFE SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>10-8-87</u> to <u>10-9-87</u> , that (I) (we) last saw the deceased alive on <u>10-8-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Robert T. Thibadeau</u>						22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED 10-9-87		
22e PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU						22f ADDRESS Rockville, Md 20852				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE OCT. 13, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901						25a DATE OF DEATH OCT 19 1987 25b REGISTRAR'S SIGNATURE <u>Julia Benson-Landree</u>				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edwin H. Anderson</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 19 87</i>		2b HOUR <i>2:50 AM</i>
3 SEX <i>male</i>	4 RACE <i>CAUCASIAN</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>12 26 14</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS	IF UNDER 5 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ILLINOIS</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>	
10 CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>D.C. TRANSIT.</i>	12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>MARYLAND</i>		13b COUNTY <i>MONTGOMERY</i>	13c CITY OR TOWN <i>ROCKVILLE</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <i>17700 RIDGE DRIVE 20853</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>HARVEY ANDERSON</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HELEN UNKNOWN</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO. <i>303-18-5557</i>		17 INFORMANT <i>PEARLE D. ANDERSON/WIFE/SAME AS 13</i>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One hour</i> <i>2 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Sepsis</i>					
19a DATE OF OPERATION <i>10-9-87</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>coronary artery disease</i>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>10-5</i> , 19 <i>87</i> to <i>10 19</i> , 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>10-18</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Joann Urquhart</i>		DEGREE <i>MD</i>		22c DATE SIGNED <i>10-19-87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joann Urquhart</i>		22e ADDRESS <i>5454 Wisconsin Ave Chevy Chase Md</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>OCT 22 1987</i>	23c NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		23d LOCATION (TYPE OR PRINT) <i>BRENTWOOD PRINCE GEORGES MD</i>
24 FUNERAL DIRECTOR <i>FRANCIS J. COLLINS, JR.</i>		25a DATE REC'D BY REGISTRAR <i>OCT 22 1987</i>		25b REGISTRAR'S SIGNATURE <i>J. Davidson</i>	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					

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18 OCT 1961

W. P. C.

18 OCT 1961

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29822

1 DECEASED NAME (TYPE OR PRINT) Marjorie Archbold			2a DATE OF DEATH MONTH DAY YEAR 10-7-87			2b HOUR 4:50 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3-25-09		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NJ		7b CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse (LPN)		12b KIND OF BUSINESS OR INDUSTRY Health Care		
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 410 Gruenther Ave., 20851	
14 FATHER'S NAME FIRST MIDDLE LAST John Glover			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b NONE (IF YES, GIVE WAR OR DATES)		16c SOCIAL SECURITY NO. 153 28 8408		17 INFORMANT ADDRESS Gerald Archbold, Sames as item 13. (Son)			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute Congestive Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute Renal failure; Carcinoma of the lung, metastatic, COPD</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>87</u> , to <u>10/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>William</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/8/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wilhelmina G. Garing M.D.</u>			22e ADDRESS <u>4912 AORIAN ST Rockville MD 20853</u>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10-09-87		23c NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Riverdale, PG Co., Md		
24 FUNERAL DIRECTOR NAME W. W. Chambers Co., Inc., 8655 Georgia Ave., Silver Spring, MD					25a DATE REC'D. BY REGISTRAR OCT 15 1987				
25b REGISTRAR'S SIGNATURE <u>John Davidson</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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4 - ALL INFORMATION

SECRET

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEDRO E AREU			2a. DATE OF DEATH MONTH DAY YEAR 10/10/87		2b. HOUR 3:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 14, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker	12b. KIND OF BUSINESS OR INDUSTRY Riggs Nat.	
13a. STATE Md.	13b. COUNTY Mont	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11495 Columbia Pike 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Eloy Areu		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Auelina DelCampo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 578 58 0807		17. INFORMANT ADDRESS Esther Areu (Wife) Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) ACUTE MYOCARDIAL INFARCTION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years 2 hours
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERLIPIDEMIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 10/10 19 87 to 10/10 19 87 that (1) (the) last saw the deceased alive on 10/10 19 87 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.					
22b. SIGNATURE Martín S. Kanovsky		DEGREE MD		22c. DATE SIGNED 10/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN S. KANOVSKY		22e. ADDRESS 5401 Western Ave. N.W. Washington, DC 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/13/87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS 11800 New Hamp. S.S. Md.		25a. DATE REC'D. BY REGISTRAR OCT 13 1987	
				25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DGI FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) PAUL HENRY Arnold			2a DATE OF DEATH MONTH DAY YEAR OCT. 1- 1987			2b HOUR 11:30 P.M.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JULY 24 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7 IF BORN IN FOREIGN COUNTRY COUNTRY FIRST MIDDLE LAST MD	
8 BIRTHPLACE COUNTRY PENNA		9b CITIZEN OF WHAT COUNTRY? U. S. A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) PRINTER		12b KIND OF BUSINESS OR INDUSTRY PRINTING	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY PR. GEO.		13c CITY OR TOWN TAKOMA PARK		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7900 GLENSIDE DRIVE 20912	
14 FATHER'S NAME FIRST MIDDLE LAST MILES ARNOLD			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N.		16b SOCIAL SECURITY NO. 220 34 8702		17 INFORMANT ADDRESS RUSSELL B ARNOLD 90 QUANT ACRES DR. S.S. MD					
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last b) Intermittent Heart Disease DUE TO, OR AS A CONSEQUENCE OF c) years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic Renal Failure									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 2, PART 3, OR PART 4)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET 7120		CITY OR TOWN MD		COUNTY MD	
22a I certify that (1) this hospital attended the deceased from 7:40 19 10 to 10:00 19 87 that (2) I last saw the deceased alive on 10-1-87 and that in my own opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) (saw the body after death)									
22b SIGNATURE [Signature]				DEGREE				22c DATE SIGNED 10/2/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. LEIBOWITZ, M.D.				22e ADDRESS MICHAEL E. LEIBOWITZ, M.D. 11120 New Hampshire Ave., Ste 305 Silver Spring, MD 20904					
23a BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b DATE Oct 4. 1987		23c NAME OF CEMETERY OR CREMATORY Deary Washington Cemetery		23d LOCATION CITY OR TOWN Adelphi		COUNTY MD	
24 FUNERAL DIRECTOR NAME Takoma Funeral Home				24a ADDRESS 254 Carroll St NW, Washington, D. C.		25a DATE REG. BY REGISTRAR OCT 06 1987			
				REGISTRAR'S SIGNATURE [Signature]					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies, page 1, and 2, and file in the office of the funeral home after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 27 is marked on item 18, show any injury or other traumatic event, for medical certification and the certificate must be signed by a medical examiner.

DHMH - 10-60M-7-84
(VRA-18, 4)

085808 OCT-501

RECEIVED OCT 10 1950

MAILED

MICHAEL E. LEBOWITZ, M.D.

2001 Street NW 2000
MICHAEL E. LEBOWITZ, M.D.

OCT 08 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HAROLD B. ATKINSON, SR.			2a. DATE OF DEATH MONTH DAY YEAR October 12, 1987			2b. HOUR 5:15 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 13 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTH YEAR IF UNDER 1 YEAR MONTH YEAR	
7a. BIRTHPLACE (COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOME - same address as #13				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMIN. ASST.		12b. KIND OF BUSINESS OR INDUSTRY RED CROSS	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9510 BRINK ROAD 20879	
14. FATHER'S NAME FIRST MIDDLE LAST ELDRON W. ATKINSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE LEIN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-44-5890		17. INFORMANT HAROLD B. ATKINSON, JR.		ADDRESS CHARLOTTESVILLE, VIRGINIA			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Atherosclerosis, Cardiac DUE TO, OR AS A CONSEQUENCE OF (c) Generalized.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c OR PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 19 47 to Oct. 12 87 that I last saw the deceased alive on Aug. 8 87 and that in my opinion death occurred on the date and hour and from the causes stated.									
22a. SIGNATURE Jack Schumacher M.D.						DEGREE M.D.		22c. DATE SIGNED 10-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK SCHUMACHER, M.D.						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Oct. 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		
24. FUNERAL DIRECTOR NAME Barber Funeral Home, Layonsville, Md.						25. DATE REC'D. BY REGISTRAR OCT 15 1987			

06073 OCT 1961



06073 OCT 1961

070095 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edith W. Austin						2a. DATE OF DEATH MONTH DAY YEAR 10 25 87				2b. HOUR 5:12 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 29 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Earl V. Wolford						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna May Kellogg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Arthur A. Austin-son- (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Cancer of the lung with metastasis (2) Paraplegia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Jan 8, 19 85, to 10/25, 19 87 that (I) (we) last saw the deceased alive on 10/25, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan R. Gair MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/25/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. Gair MD						22e. ADDRESS 11700 Old Columbia Ave Silver Spring, Md 20904					
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 10-27-1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION (IF UNDER 100 YARDS FROM HOME, GIVE STREET ADDRESS) Alexandria		23e. COUNTY Virginia			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home						11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29327

REG NO

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Robert Lee Bain			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10 10 1987			2b HOUR 0640 AM		
3 SEX Male	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR 10 22 1968	6 AGE (IN YEARS) (LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YR MONTHS DATE HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 10 1987	2d HOUR 640 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Knox Co., Ky.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hosp				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder, Retired		12b KIND OF BUSINESS Heating
13a STATE MD			13b COUNTY Montgomery	13c CITY OR TOWN Germanstown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 19515 Frederick Rd		
14 FATHER'S NAME FIRST MIDDLE LAST Gregg Bain			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angeline Jones					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. WWII 407-03-6896		17 INFORMANT ADDRESS Mary P. Bain (Wife) 19515 Frederick Rd., Germantown, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Coronary Arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8 PART I OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <u>John Tamber</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		DATE SIGNED 10-10-87
EXAMINER'S NAME (TYPE OR PRINT) John Tamber		ADDRESS 8218 Wisconsin Ave		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE October 13, 1987	23c NAME OF CEMETERY OR CREMATORY Thornrose Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Staunton, Augusta, Va.
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/Bethesda Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814			25a DATE REC'D. BY REGISTRAR OCT 14 1987	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. OF THIS CERTIFICATE IN ITEM 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

008635-001201

20% COTTON LITER



OCT 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY RUTH BAKER			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987		2b. HOUR 9:21 pm	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 3, 1895		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) University Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.		
12a. USUAL OCCUPATION (TYPE OF WORKER, FARM, ETC. OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None				

13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 228 East 7th Street/21701			

14. FATHER'S NAME FIRST MIDDLE LAST William Franklin Spring		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Naomi Cooksey	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 220-48-5985		17. INFORMANT ADDRESS Mr. Aubrey Lee Baker 4900 Battery Lane #112 Bethesda, Md. 20814	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) /no		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h.	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 1 OR PART 2)	
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21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT PLAY <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from 10/2 to 10/4 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If two (doctors) did not see the body after death)		19 87 to 10/4 19 87 that I (we) last saw the deceased alive on 10/4	
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22b. SIGNATURE Myron L. Lenkin		DEGREE M.D.		22c. DATE SIGNED 10/13/87	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN M.D.		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-1987		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg, Loudon, Virginia	
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24. FUNERAL DIRECTOR'S NAME R. E. DAILEY & SON, PA		24b. ADDRESS 1201 N. Market Street Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR 06109 1987		25b. REGISTRAR'S SIGNATURE [Signature]	
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067699 OCT-87

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER V BALL			2a. DATE OF DEATH MONTH DAY YEAR 10-4-87			2b. HOUR 9 ⁵⁵ A.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07-17-01		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Railroad				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3314 Coquelin Terrace/ 20815	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Ball			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Butterworth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Not Available		17. INFORMANT Mary Lee Anderson 3314 Coquelin Terrace Chevy Chase, Maryland 20815 (Daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pneumonia</u>										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 87</u> to <u>present</u> 19 <u>87</u> that (I/we) last saw the deceased alive on <u>Oct. 3 19 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.										
22b. SIGNATURE John B. Umkau MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umkau MD			22e. ADDRESS 8805 Conn. Ave., Chevy Chase MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE October 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville/Montgomery/Maryland			
24. FUNERAL DIRECTOR (NAME) Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814			25a. DATE REC'D. BY REGISTRAR OCT 05 1987		25b. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #1 and #2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Medical Examiner's Office

06566 001-201

06566 001-201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Annabel L. Barrett			2a DATE OF DEATH MONTH DAY YEAR October 25, 1987		2b HOUR 6:55P M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR June 12, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b KIND OF BUSINESS OR INDUSTRY Public School	
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4317 Havard Street / 20906	
14 FATHER'S NAME FIRST MIDDLE LAST James Lombard		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17 INFORMANT ADDRESS Mr. Edward C. Barrett, Jr., Son, Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u> <u>5 years</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome Osteoarthritis CHF</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 (a) & PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (this hospital) attended the deceased from <u>May 31, 1983</u> to <u>Oct 25, 1987</u> that (we) last saw the deceased alive on <u>Oct 6, 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.					
22b SIGNATURE <u>James R. Moore, Jr., M.D.</u>		DEGREE MD	ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e DATE SIGNED October 27, 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore, Jr., M.D.		22e ADDRESS 207 Brookes Avenue Gaithersburg, Maryland 20877			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE October 29, 1987	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia		
24 FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Home/ 300 W. Montgomery Ave. Rockville, Inc. Rockville, MD. 20850		25a DATE REC'D. BY REGISTRAR OCT 27 1987			
		25b REGISTRAR'S SIGNATURE <u>Julia Tinsley-Budner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29331

1. DECEASED NAME (TYPE OR PRINT) No Michael - Barta			2a. DATE OF DEATH MONTH DAY YEAR 10-4-87		2b. HOUR 0120 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Manager	12b. KIND OF BUSINESS OR INDUSTRY Little Man & Son's Fur's	
13a. STATE Maryland	13b. COUNTY P.G. Co.	13c. CITY OR TOWN Cheverly	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6209 Forest Rd / 20785	
14. FATHER'S NAME FIRST MIDDLE LAST Michael - Barta		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natalie - Packwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 567-48-1313	17. INFORMANT Natalie Sellers Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>multistate pericarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 9/16/87 to 10/4/87 that (we) lost saw the deceased give on 10/4/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true, I did not view the body after death)					
22b. SIGNATURE <i>Lewis Dennis MD</i>		DEGREE		22c. DATE SIGNED 10/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Dennis MD		22e. ADDRESS 6201 Greenbelt Rd. College Park MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/6/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Inc.		ADDRESS Riverdale Md.		25a. RECEIVED BY REGISTRAR OCT 09 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

REG NO

24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NAME 5130 Wisconsin Ave, NW,	ADDRESS Washington, D.C. 20016	OCT 28 1987	<i>Julia Davidson-Pandora</i>

25b REGISTRAR'S SIGNATURE

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OCT 28 1987

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29333

1. DECEASED NAME (Last, first, middle, or print) Edward W. Bauman, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 10 16 87			2b. HOUR 6:29 PM		
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 88		
7a. BIRTHPLACE (COUNTRY, STATE OR FOREIGN) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10826 Lorain Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY Nat. Slag Assoc.		
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Christian --- Bauman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna --- Zurcher		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I				
16b. SOCIAL SECURITY NO. 295-07-2738		17. INFORMANT ADDRESS 5214 Wenhawken Rd. Dr. Edward W. Bauman, Jr., Bethesda, MD						
18. CAUSE OF DEATH (Enter only one cause per line) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Mins Yrs
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Aspiration Pneumonia</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1987</u> to <u>Oct. 16, 1987</u> that (I) (we) last saw the deceased alive on <u>Oct. 14, 1987</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
23a. SIGNATURE <u>Albert H. Grollman</u>				DEGREE MD - PHYSICIAN		23b. DATE SIGNED 10/16/87		
23c. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT H. GROLLMAN MD				23d. ADDRESS 106 Spring Hill Rd. Silver Spring, MD 20910				
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f. DATE 10/19/87		23g. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23h. LOCATION CITY OR TOWN COUNTY Brentwood, MD		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE Julia T. ...		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Please do not detach, mutilate, or remove.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified.

Clifford Medical Examiner

008730 OCT 28 21

RECEIVED

TO THE DIRECTOR, BUREAU OF REVENUE
FROM THE COMMISSIONER, BUREAU OF CUSTOMS
SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b DATE OF DEATH MONTH DAY YEAR		2c HOUR	
WILLIAM A. BAXTER				October 12, 1987		8:30 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR IF UNDER 24 HRS	
male	white	6 10 32		55			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			Montgomery County MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital		Sales Engineer		Electronics		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b STATE	13c COUNTY	13d CITY OR TOWN	13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f STREET ADDRESS / ZIP CODE		
Maryland		Montgomery	Silver Spring		1332 Chilton Drive 20904		
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George Norman Baxter		Bernette Joiner					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
YES		Korean 221-20-4830		Joan S. Baxter 1332 Chilton Drive Silver Spring, MD 20904			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTRAVENTRICULAR CEREBRAL HEMORRHAGE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>10/12/87</u> to <u>10/12/87</u> that (I) <u>did</u> not see the deceased prior to, on, above, (I) <u>did</u> not view the body after death.		22b SIGNATURE OF ATTENDING PHYSICIAN <u>Lawrence A. Marcus MD</u>		22c DATE SIGNED <u>10/12/87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
Lawrence A. Marcus		10313 Georgia Ave Silver Spring, MD 20902					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Cremation		OCT 14, 1987		Metropolitan Crematory Alexandria, Fairfax, Virginia			
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Beall Funeral Home		16000 Annapolis Road Bowie, MD 20715-3043		OCT 21 1987		J. Swiden-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		7b HOUR	
MARGUERITE		Bogue		BAYNE				10		9		19		87		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	6 10 1909		78 YRS						10		9		19		87	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
Washington D.C.		United States						Montgomery County								MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
Olney		Montgomery General Hospital		Sales		Shoes											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS									
Maryland		Montgomery		Burtonsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15721 Allnutt Lane								20866	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
Albert		Franklin		Bogue		Laura		NMN								Jarvis	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT													
No		N/A		578-01-0167		Lornelle Blankenship		333 Seth Place								Rockville, Md. 20850	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
		Hypertensive arteriosclerotic cardiovascular disease															
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE													
22a I certify that I took charge of the remains described above, held on death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
M.D.		Assistant		10-10-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Mario R. Golle, Jr., M.D.		111 Penn St., Balto., MD 21201															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE											
Cremation		10/12/87		Metropolitan Crematory		Alexandria Va.											
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE													
Tyson Wheeler, Funeral Home, Inc.		OCT 14 1987		Julia Davidson-Randner													
1331 Rockville Pike Rockville, Md. 20852																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Glenn

Steven

Bean

2a DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 10 15 19 87 7b HOUR M

3 SEX
Male

4 RACE
White

5 DATE OF BIRTH
June 19 1953

6 AGE IN YEARS
34

IF UNDER 1 YR
MONTHS DAYS HOURS MIN

IF UNDER 24 HRS
MONTHS DAYS HOURS MIN

2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 15 19 87 2d HOUR M 1:15 P

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b CITIZEN OF WHAT COUNTRY?
USA

Separated

MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County MD

10 CITY OR TOWN OF DEATH
Takoma Park

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7348 Carroll Avenue

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b KIND OF BUSINESS OR INDUSTRY
Roofing Al Brown Roofing Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b CITY OR TOWN Silver Spring

13c INSIDE CITY LIMITS? YES ☒ NO ☐ 13d STREET ADDRESS 508 Valley Brook Dr. 20904

14 FATHER'S NAME
Horace

Frederick Bean

15 MOTHER'S MAIDEN NAME
Helen

Sylvia Robey

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) N/A

16b SOCIAL SECURITY NO.
N/A 163-44-0082

17 INFORMANT ADDRESS
Horace F. Bean-Father- (same as 13e)

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Narcotic Intoxication

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 10-15 19 87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Subject used drugs

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)
unknown

21f LOCATION
STREET unknown

CITY OR TOWN COUNTY STATE
Montgomery, MD

22a I certify that took charge of the remains described above, and on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Dennis F. Smyth TITLE (SPECIFY)
Assistant MEDICAL EXAMINER

DATE SIGNED 10/16/87

EXAMINER'S NAME (TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St.

Balto.MD.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b DATE
10-19-1987

23c NAME OF CEMETERY OR CREMATORY
Union Cemetery

23d LOCATION
CITY OR TOWN COUNTY STATE
Burtonsville Montgomery Md.

24 FUNERAL DIRECTOR

Hines/Rinaldi Funeral Home

ADDRESS 11800 N.H. Ave.,

Silver Spring, Md.

25 DATE RECD BY REGISTRAR

OCT 20 1987

25b REG. MARKS

John Sullivan

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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OCT 30 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Kathleen S. Beck			2a. DATE OF DEATH MONTH DAY YEAR 10-4-87			2b. HOUR 1345 M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 05, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN 78		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Specialist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18728 Nathans Place/20879	
14. FATHER'S NAME FIRST MIDDLE LAST William T. Sutcliffe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Stanley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 240 22 0241		17. INFORMANT (daughter) Kathleen L. Beck		ADDRESS Same as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) minutes									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension, Cardiovascular Disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 7/31 19 74 to 10/4 19 87 , that (1) (the last saw the deceased alive on 9/15 19 87 and that in my own opinion death occurred on the date and hour and from the causes stated above; (2) (I) (did not) view the body after death.										
22b. SIGNATURE Stephen Newman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman			22e. ADDRESS 19261 Mont. Vill. Ave, Gaithersburg							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville/Montgomery/Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc.						25a. DATE REC'D BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE Davidson		
300 West Montgomery Avenue Rockville, Maryland										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT If item 21 is marked, item 18 shows any injury, or other immediate event, medical examination is to be held at once.

BP

DHMH - 16 60M 7-B4
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James D Bell			2a DATE OF DEATH MONTH DAY YEAR 10-15-87		2b HOUR AM PM 6:25 A
3 SEX M MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR 9 4 22		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLUMBER		12b KIND OF BUSINESS OR INDUSTRY ADAM CRAIG, INC
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY PR GEORGES 13c CITY OR TOWN LAUREL			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM J. BELL			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL M. HAZEN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII		16b SOCIAL SECURITY NO. 577-28-5842		17 INFORMANT ADDRESS ALICE M. BELL/WIFE/SAME AS 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary edema. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Chronic Pulmonary disease.					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from April 19 83 to 10. 15. 19 87 that (I) (we) last saw the deceased alive on 10. 14. 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Rajindra K. Sarin		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10.15.87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) RATINDRA K. SARIN		22e ADDRESS 9801 Pa Ave SS MD 20902			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT17,1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM	
23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD					
24 FUNERAL DIRECTOR FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25 DATE RECEIVED BY REGISTRAR OCT 22 1987 26 REGISTRAR'S SIGNATURE	

068555 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29337

1. DECEASED NAME (TYPE OR PRINT) JANINA		2a. DATE OF DEATH MONTH DAY YEAR 10-11-87		2b. HOUR 8:56 A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-31-10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 76 YRS	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Translator		12b. KIND OF BUSINESS OR PUBLISHING CO. McGraw-Hill		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Graczyk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Wierbuski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> (UNKNOWN) <input type="checkbox"/> (IF YES, GIVE DATES) N/A	
16b. SOCIAL SECURITY NO 577-48-0944		17. INFORMANT (FRIEND) Natalie Kristofovich		17a. ADDRESS 114 South Brook Lane Beth., Md. 20814	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multi system failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured abdominal aortic aneurysm				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 weeks 7 weeks	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION 8/18/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b OR PART 2)	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE BETHESDA, MD. 20814	
22a. I certify that (1) (this hospital) attended the deceased from 8/18 19 87 to 10/11 19 87 that (1) (we) last saw the deceased alive on 10/11 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Louis Korloff		DEGREE MD		22c. DATE SIGNED 10/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS KORLOFF, MD		22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-15-1987		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery Alex. Va.	
23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Va.		23e. DATE RECD BY REGISTRAR OCT 13 1987			
23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall		23g. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages are to be given to the funeral director. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

10 OCT 1981

1. The first part of the report is a description of the project. It is a study of the effects of the new drug on the patients. The study was conducted in a hospital setting. The patients were given the drug for a period of six weeks. The results of the study are shown in the table below.

2. The second part of the report is a discussion of the results. The results show that the new drug has a significant effect on the patients. The patients who were given the drug showed a significant improvement in their condition. This is a positive result and suggests that the new drug may be effective in treating the condition.

3. The third part of the report is a conclusion. The conclusion is that the new drug is effective in treating the condition. The results of the study support this conclusion. The patients who were given the drug showed a significant improvement in their condition. This is a positive result and suggests that the new drug may be effective in treating the condition.

4. The fourth part of the report is a list of references. The references are listed in alphabetical order. The references are as follows:

- 1. Smith, J. (1980). The effects of the new drug on the patients. *Journal of Medicine*, 100, 1-10.
- 2. Jones, A. (1981). The effects of the new drug on the patients. *Journal of Medicine*, 101, 1-10.
- 3. Brown, C. (1982). The effects of the new drug on the patients. *Journal of Medicine*, 102, 1-10.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FELIX C. BERGES				2a DATE OF DEATH MONTH DAY YEAR OCTOBER 29, 1987			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MAY 2, 1902		2b HOUR 8:55 A	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN		7b CITIZEN OF WHAT COUNTRY? CUBA		6 AGE (IN YEARS, LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR IF UNDER 1 YEAR	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND				12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12c KIND OF BUSINESS OR INDUSTRY RETAIL SALES	
13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 10100 NEW HAMPSHIRE AVENUE 20903	
14 FATHER'S NAME FIRST MIDDLE LAST MARIANO BERGES				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERESA MORTE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 215-74-7890		17 INFORMANT NEPHEW ADDRESS 884 DIAMOND DRIVE			
				LUIS FERNANDEZ / GAITHERSBURG, MD 20878			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Colon Cancer with liver metastasis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (b) (this hospital) attended the deceased from 1/18/87 19 84 to 10/29/87 19 87 that (b) (we) lost saw the deceased alive on 10/10/87 19 87 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Mark H. Smith</i>				DEGREE PHYSICIAN		22c DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Smith S. Ho, M.D.				22e ADDRESS 7610 Carroll Ave. Takoma Park, MD 20912			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 31, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE NOV 06 1987 <i>Walter R. Riddell</i>			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901							

BP

1151 NOV-20-61

ON 11-20-61

1151 NOV-20-61

NOV 20 1961

068502 OCT 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA HELEN BERKOW			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 7, 1987			2b. HOUR 4:00a _M			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MAY 4 1906		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALT. MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH POTOMAC		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7317 BROOKSTONE COURT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER.		12b. KIND OF BUSINESS OR INDUSTRY RETAIL-INDUS.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7317 BROOKSTONE CT: 20854	
14 FATHER'S NAME FIRST MIDDLE LAST LOUIS COHEN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA KATSEF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17 INFORMANT SON ADDRESS BETHESDA, MD 20814 EDWARD BERKOW: 4606 CHESTNUT ST.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>6 YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Vascular Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>MAY 19 87</u> to <u>OCTOBER 7, 19 87</u> that (1) we last saw the deceased alive on <u>Sept 19 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did not) view the body after death.									
22b. SIGNATURE <u>Gary Fisher MD</u>						DEGREE MD		22c. DATE SIGNED 10/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GARY FISHER, MD						22e. ADDRESS CHEVY CHASE, MD 5530 WISCONSIN AVE., #505;			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/11/87		23c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DATE REC'D. BY REGISTRAR OCT 13 1987 REGISTRAR'S SIGNATURE <u>John Darden</u>									

age 4 may be

TO HOSPITAL, ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

008203 OCT 14 87

OCT 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Andrew

FIRST

MIDDLE

LAST

BESTE

2a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 2b HOUR
ESTI. MATED ☐ 10 25 87 330 AM

3 SEX

MALE

4 RACE

WHITE

5 DATE OF BIRTH

1 27 90

6 AGE (IN YEARS)

97 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c DATE PRONOUNCED DEAD

10 25 87 330 AM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Minnesota

7b CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD

10 CITY OR TOWN OF DEATH

Bethesda

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Suburban Hospital

12a USUAL OCCUPATION (TYPE OF WORK)

Teacher & Dairy Farmer

12b KIND OF BUSINESS

Education & Farming

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Minnesota

13b COUNTY

Stearns

13c CITY OR TOWN

Freeport

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

Box 201

13f ZIP CODE

56331

14 FATHER'S NAME

Conrad

MIDDLE

LAST

Beste

15 MOTHER'S MAIDEN NAME

Clara

MIDDLE

LAST

Woeste

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

476-38-2492

17 INFORMANT

8921 Charred Oak Dr. Celestine B. Converse Bethesda, Md.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

888

IMMEDIATE CAUSE (a)

Cardio Respiratory arrest.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

Coronary arteriosclerosis.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Fractured Hip

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING CAUSE OF DEATH

21b TIME OF INJURY

3:45 AM 9 29 87

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Fall at Home.

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

None

21f LOCATION

8921 Charred Oak Drive Bethesda Mont. Md.

22a I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from

Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

John Tauber

M.D.

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

10-25-87

EXAMINER'S NAME (TYPE OR PRINT)

John Tauber

ADDRESS

8218 Wisconsin Ave Bethesda Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

Oct. 31, 1987

23c NAME OF CEMETERY OR CREMATORY

St. Alexius Cemetery

23d LOCATION

West Union

COUNTY

Minnesota

24 FUNERAL DIRECTOR

Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814

25a DATE REC'D. BY REGISTRAR

OCT 27 1987

25b REGISTRAR'S SIGNATURE

Julia Gordon-Rudner

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

18 25 100 1 50 0

18 25 100 1 50 0



18 25 100 1 50 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Geraldine R. Bird			2a. DATE OF DEATH MONTH DAY YEAR October 19, 1987		2b. HOUR 5:20P M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5100 Dorset Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5100 Dorset Ave. 20815		14 FATHER'S NAME FIRST MIDDLE LAST John Riley		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Myers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-42-9835		17 INFORMANT ADDRESS Lyle O. Armel II 6736 N. 27th St. Arl., VA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours 10 YEARS 6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 1979 , 19____, to 10-19 , 19 87 , that (2) we last saw the deceased alive on 10-6-87 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Phillip R. James				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip R. James				22e. ADDRESS 5401 Western Ave. Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Arl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arl., VA	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D BY REGISTRAR OCT 26 1987			
				25b. REGISTRAR'S SIGNATURE John F. ...			

088023 OCT 27 67

Female
White
DOB: 07, 1905
U.S.A.
John
Mary
Alice
5100 Howard Ave. 2015
200-42-2555 A 10-11-67 11-11-67

11-11-67
11-11-67
11-11-67

10-22-67
10-22-67
10-22-67

10-22-67
10-22-67
10-22-67

07/84
25M

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5)

FOR 1- STATE 12/8/87 Job Per Med REGISTRAR Exam						STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.					
2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR x 10 12 19 87						2b. HOUR AM PM M											
3 SEX MALE						4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB 25 49		6 AGE (IN YEARS LAST BIRTHDAY) YRS 38		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC						7b CITIZEN OF WHAT COUNTRY? USA						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Gaithersburg						11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 118 Duval Lane #102						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARTS MANAGER		12b KIND OF BUSINESS OR INDUSTRY HERSONS			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a STATE MARYLAND						13b COUNTY MONTGOMERY		13c CITY OR TOWN GAITHERSBURG			
13d INSIDE (CITY LIMITS)? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e STREET ADDRESS HONDA 118 DUVAL LANE #102											
14 FATHER'S NAME FIRST MIDDLE LAST KLAUD K. BITTNER						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET L. HANSON											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b SOCIAL SECURITY NO. 213-56-4630						17 INFORMANT FATHER ADDRESS 1801 BRISBANE ST. SILVER SPRING, MD 20902					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Asphyxia																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Primary						21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-12 19 87						21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Unknown					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home						21f LOCATION STREET CITY OR TOWN COUNTY STATE 118 Duval Lane, Gaithersburg, Mont, Md.					
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE Mario F. Golle Jr.						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 10-14-87					
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.						ADDRESS 111 Penn St., Balto., MD 21201											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE OCT 16, 1987		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD							
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						25a DATE REC'D BY REGISTRAR OCT 22 1987				25b REGISTRAR'S SIGNATURE [Signature]							

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X

X

000000 000000

068438 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Lillian		Blankfeld		10 11 87		3:35 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	White	7 15 02		85			
7a. BIRTHPLACE (CITY OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
POLAND	U.S.A.				Montgomery Co. MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		PROPRIETOR		BOWLING ALLEY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		SIL. SPR.		20901	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
MORRIS		TENDLER		NO			
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF			
217-34-0038		ALVIN FRIEDMAN		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Pneumonia		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from 9/24 19 87 to 10/11 19 87 that (1) (we) lost saw the deceased alive on 10/10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did (did not) view the body after death	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
Ernest Oser		10/11/87		DR. IRNEST OSER			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10/11/87		MT. LEBANON		ADELPHI - PG - MARYLAND	
24. FUNERAL DIRECTOR'S NAME		25. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG MEMORIAL CHAPEL		OCT 13 1987		Julia Davidson-Rodriguez			
1170 ROCKVILLE PIKE: ROCKVILLE, MD							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certain papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, show any injury, accident, or other traumatic event. The medical examiner will be called at once.

10 41 T20 0 0 1 0 0 0

15928-01

7

069028 OCT 20 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Nelson R Blemly			2a DATE OF DEATH MONTH DAY YEAR 10 14 87		2b HOUR 5:55 AM
3 SEX MALE	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 8 28 23		6 AGE (IN YEARS LAST BIRTHDAY) 64	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORKING LIFE) Chief of Radiology	12b KIND OF BUSINESS OR INDUSTRY WRAMC	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Potomac	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 12327 Overpond Way/20854
14 FATHER'S NAME FIRST MIDDLE LAST Walborn Christian Blemly		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide Marie Luther			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 103 18 9146		17 INFORMANT (Wife) ADDRESS Phyllis B. Blemly Same as line #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured abdominal aortic aneurysm					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Artery Disease					
19a DATE OF OPERATION 10/13/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aneurysm		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 10/13 87 to 10/14 87	
22a I certify that (1) (this hospital) attended the deceased from [] to [] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death.					
22b SIGNATURE SARBY P. LEVIN, MD		22c DATE SIGNED 10/18/87		22d ADDRESS 4801 MASS AVE, N.W. WASH DC	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 19, 1987	23c NAME OF CEMETERY OR CREMATORY Arlington National Cem		23d LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia
24 FUNERAL DIRECTOR Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland		25 DATE BECAME BALTIMORE REGISTRAR'S SIGNATURE OCT 16 1987			

Released by Francis C. Mayle, M.D.

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove embossings, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, a medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reuben Block					2a. DATE OF DEATH MONTH DAY YEAR 13 Oct 87			2b. HOUR 8:10 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 30 18		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. UNDER 1 YEAR MONTHS DAYS YRS		8. UNDER 24 HRS HOURS MIN. MIN.	
7a. BIRTHPLACE STATE OR FOREIGN WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY GROCERY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND				13b. CITY OR TOWN HYATTSVILLE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 5631 SARGENT ROAD 20782			
14. FATHER'S NAME FIRST MIDDLE LAST HARRY BLOCK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL (UNASCERTAINABLE)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 579-46-8339		17. INFORMANT ADDRESS ROSE S. BLOCK, 5631 SARGENT ROAD HYATTSVILLE, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Biliary Sepsis with Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Obstructive jaundice DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Pancreas with metastasis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 3m 3m	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, GI hemorrhage, Heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7411 Riggs Rd Hyattsville MD 20783							
22a. I certify that (I) (this hospital) attended the deceased from Oct 7 1987 to Oct 13 1987 that (I) (we) last saw the deceased alive on Oct 13 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Tung P. Lee M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TUNG P. LEE, M.D.				22e. ADDRESS 7411 Riggs Rd Hyattsville MD 20783							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/16/1987		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION (CITY OR TOWN) FALLS CHURCH, VIRGINIA					
24. FUNERAL HOME NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR OCT 19 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudner			

BP _____

080495-01238

1968
[Faint, mostly illegible text follows, appearing to be a list or report with several lines of handwriting.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. The medical examiner must be notified at once if item 21 is marked or item 18 shows any injury, or other traumatic event.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) DORA W. BLUM			2a DATE OF DEATH MONTH DAY YEAR 10/10/87		2b HOUR 1:55 PM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 2-1-05		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANICURIST		12b BUSINESS OR INDUSTRY SALON
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN ROCKVILLE			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST IGNAZ WEIKERS		15 MOTHER'S MAIDEN NAME MIDDLE LAST JOSEPHINE MINA SICHTEL			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 579-12-7182		17 INFORMANT ADDRESS L. ALAN BLUM, 10205 PORTLAND ROAD SILVER SPRING, MARYLAND	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALZHEIMER'S DEMENTIA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>SEVERE DEPRESSION.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>6-13-1984</u> to <u>10-10-1987</u> , that (I) (we) last saw the deceased alive on <u>10/10/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>S. SUDHAKAR, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. SUDHAKAR				22e ADDRESS HEBREW HOME	

23a BURIAL, CREMATION, REMOVAL BURIAL	23b DATE 10/11/1987	23c NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY	23d LOCATION PRINCE GEORGE'S COUNTY MARYLAND
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a DATE REC'D. BY REGISTRAR OCT 15 1987	25b REGISTRAR'S SIGNATURE <u>Davidson-Rodriguez</u>

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67910 OCT-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Douglas Richard Beach</i>		2a DATE KNOWN OF DEATH ESTIMATED <i>Oct 3 1987</i>		2b HOUR OF DEATH <i>9:30 AM</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Feb 14 1923</i>	6 AGE IN YEARS YEARS MONTHS DAYS <i>64 YRS</i>	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Kensington</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3203 Plyers Mill Rd</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CIVIL SERVICE</i>	
13a STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c STREET ADDRESS <i>3203 Plyers Mill Rd</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>DOUGLAS W. BEACH</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SALLY BEACH</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b SOCIAL SECURITY NO. <i>223-20-8346</i>		17 INFORMANT ADDRESS <i>BEAUTIS M. BEACH SAME AS 13c</i>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John R. Rogers</i>		TITLE (SPECIFY) <i>MD</i>		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN R. ROGERS</i>		ADDRESS <i>SEMINARY RD. SILVER SPRING, MD</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b DATE <i>OCT. 4, 1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>ALEXANDRIA VA.</i>	
24 FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR. 500 UNIV. BLVD. WEST, SILVER SPRING, MD. 20901</i>				25a DATE REC'D. BY REGISTRAR <i>OCT 07 1987</i>		25b REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

87810-01-03

Deputy District Clerk

in the County of

State of New York

do hereby certify that

Charles A. ...

Wm. ...

Wm. ...

John ...

OCT 07 1907

069771

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Adolphe</u> MIDDLE <u>---</u> LAST <u>Bonnefil</u>		2a. DATE OF DEATH MONTH <u>10</u> DAY <u>16</u> YEAR <u>87</u>		2b. HOUR <u>1810</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>July</u> DAY <u>1</u> YEAR <u>1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Haiti</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY CO</u> MD
10. CITY OR TOWN OF DEATH <u>BETHESDA</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SUBURBAN HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Foreign Ser. Of.</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>State Dept.</u>
13a. STATE <u>MD</u>	13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Kensington</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Leonce</u> MIDDLE <u>---</u> LAST <u>Bonnefil</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Josephine</u> MIDDLE <u>---</u> LAST <u>Baudry</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>568-42-1087</u>		17. INFORMANT ADDRESS <u>Vivienne Bonnefil, Same address as #13.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>				<u>29 days</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Coronary Artery Disease</u>				<u>10 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Renal Failure</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (1) (this hospital) attended the deceased from <u>September 19</u> 19 <u>87</u> to <u>October 16</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>October 16</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death)				
22b. SIGNATURE <u>Allen A. Nimetz, M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>10/17/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Allen A. Nimetz, M.D.</u>		22e. ADDRESS <u>5401 Western Ave, N.W., Wash. D.C.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>10/19/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, MD</u>
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C. 20016</u>		25a. DATE OF REGISTRATION <u>OCT 23 1987</u>		
25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Rudner</u>				

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



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DATE 01-11-01 BY 60322 UCBAW

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87-29851

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST Edna			MIDDLE AGAITHA			LAST BOARMAN			2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/21 19 87			2b HOUR 8:15 P. M.								
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1904		6 AGE (IN YEARS) (LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD 10/21 19 87			2d HOUR 8:15 P. M.								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD											
10 CITY OR TOWN OF DEATH Hyattsville				11 NAME OF HOSPITAL, NURSING HOME (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator				12b KIND OF BUSINESS OR INDUSTRY C & P Telephone											
13a STATE Maryland				13b COUNTY Prince Geo.		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5805 Queens Chapel Rd., 20782													
14 FATHER'S NAME FIRST Martin						MIDDLE L.			LAST Hines			15 MOTHER'S MAIDEN NAME FIRST A.						MIDDLE Irene			LAST Hewitt		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b SOCIAL SECURITY NO. 577-01-2677				17 INFORMANT 6400 Riggs Road, 20783 John Adams, Hyattsville, Maryland															

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Pulmonary embolus

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) fracture of left hip.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

None

19a DATE OF OPERATION 10/9/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of left hip.		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10/5 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Not known.	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing home		21f LOCATION STREET CITY OR TOWN COUNTY STATE Queen's Chapel Rd., Hyattsville, Pr. George's, MD	

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE
SIGNED

11/19/87

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

Silver Spring, Montgomery County, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 26, 87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland	
24 FUNERAL DIRECTOR FRANCIS GASCHS SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a DATE REC'D BY REGISTRAR NOV 25 1987		25b REGISTRAR'S SIGNATURE Gina D. [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP
DHMH - 17
(VR A15 ME (1))

George White, Dec. 12, 1904

George White, Dec. 12, 1904

George White, Dec. 12, 1904

George White, Dec. 12, 1904

George White, Dec. 12, 1904

070355 OCT 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST: CATHLEEN MIDDLE: MARIE LAST: BOYLAND			2a DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13, 1987		2b HOUR 8:15A M						
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MARCH 22, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7505 SERAGO ROAD				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN BETHESDA		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7505 SERAGO ROAD 20817		
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH T. GAYNOR			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHARINE HAMILL								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-68-3407			17 INFORMANT ADDRESS RICHARD J. BOYLAND/HUSBAND/SAME AS 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 10 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from OCT 13 19 80 to OCT 13 19 87 that (if: (we) last saw the deceased alive on SEPT 29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Stephen W. Dejter, M.D.						DEGREE M.D.			22c DATE SIGNED 10-13-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJTER, M.D.						22e ADDRESS 6719 WILSON LANE, BETHESDA, MD 20817					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE OCT 19, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM			23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						25a DATE REC'D BY REGISTRAR OCT 29 1987		25b REGISTRAR'S SIGNATURE Julia Benson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b), or (c), the medical examiner must be notified at once.

BP

010322 OCT 30 81

2028 COLLOM 181 B

OCT 28 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HELEN M. BOYLE						2a. DATE OF DEATH OCTOBER 31, 1987				2b. HOUR 8:52 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH OCTOBER 2, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13809 BETHPAGE LANE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AD ASSISTANT		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13809 BETHPAGE LANE 20906			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK J. MURPHY, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA KELLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-3127		17. INFORMANT ADDRESS ROBERT W. BOYLE/HUSBAND/SAME AS 13							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF LEFT LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 MOS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from JANUARY 20, 1986 to NOVEMBER 2, 1987 that (I) (we) last saw the deceased alive on MAY 14, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE James A. Brown MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/2/87			
22d. ADDRESS 14801 PHYSICIANS LANE, #271 ROCKVILLE, MD 20850											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE NOV 3, 1987		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRINCE GEORGES MD					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901											
DATE RECD. BY REGISTRAR NOV 06 1987											
REGISTRAR'S SIGNATURE John Davidson-Randall											

BP

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NOV 8 1962

069729 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
Marie Blackwell Brisendine		October 18, 1987		5:30 PM	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
female	Caucasian	MONTH DAY YEAR		66 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Georgia		United States		9 BALTIMORE CITY OR COUNTY OF DEATH	
Rockville		Collingswood Nursing Center		MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK OR NIGHT WORKING (IFE))	
Rockville		Collingswood Nursing Center		Physician's Assistant	
12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS / ZIP CODE		13b	
Medicine		8900 Melwood Road 20817			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
James Henry Blackwell		Carrie Belle Wyatt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		252-20-6502		Ned H. Brisendine same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of breast with distant metastasis</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>acute respiratory failure</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		70a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (we) attended the deceased from <u>10/2</u> , 19 <u>87</u> to <u>October 16</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
Frankie Westphal		M.D.		October 19, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Frauke Westphal		809 Viers Mill Rd Rockville, Md 20851			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		October 21, 1987		Parklawn Memorial Park	
				Rockville	
				COUNTY Maryland	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert A. Pumphrey, Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814		OCT 23 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

069525 OCT 28 1987

29355

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Louis M Broad

2a DATE OF DEATH MONTH DAY YEAR
10 8 87

2b HOUR 50
8 AM

3 SEX M ALE

4 RACE W WHITE

5 DATE OF BIRTH MONTH DAY YEAR
8 8 20

6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
67

7a BIRTHPLACE (STATE OR FOREIGN)
PENNSYLVANIA

7b CITIZEN OF WHAT COUNTRY?
USA

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD

10 CITY OR TOWN OF DEATH
SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSPITAL

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN

12b KIND OF BUSINESS OR INDUSTRY
FURNITURE

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN SILVER SPRING 13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE
1131 UNIVERSITY BOULEVARD, WEST 20902

14 FATHER'S NAME (UNASCERTAINABLE) MIDDLE (UNASCERTAINABLE) LAST (UNASCERTAINABLE)

15 MOTHER'S MAIDEN NAME (UNASCERTAINABLE) MIDDLE (UNASCERTAINABLE) LAST (UNASCERTAINABLE)

16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES ☐ NO ☒ (IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.
178-05-8900

17 INFORMANT
LEAH M. BROAD, SILVER SPRING, MARYLAND

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) EMPYEMA AND Sepsis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CHRONIC RENAL failure
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
1 year

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: c

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☒ XX

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from JANUARY 19 87 to OCT 8 19 87 that (I) (we) last saw the deceased alive on OCT 8 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE
STEPHEN HELLMAN

22c DATE SIGNED
10/8/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN HELLMAN

22e ADDRESS
6246 MONTROSE RD ROCKVILLE MD

23a BURIAL, CREMATION, REMOVAL
BURIAL

23b DATE
10/11/1987

23c NAME OF CEMETERY OR CREMATORY
KING DAVID MEMORIAL GARDEN FALLS CHURCH, VIRGINIA

23d LOCATION CITY OR TOWN COUNTY STATE

24 DONOR DIRECTOR TO STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.

25 DATE REC'D BY REGISTRAR
OCT 15 1987

26 REGISTRAR'S SIGNATURE
JULIA H. HARRIS

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other significant event, the medical examiner must be called at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

071283 NOV

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Lillian

B.

Brodsky

2a. DATE KNOWN OF DEATH ☒ MATED ☐ 10/28 19 87 2b. HOUR M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

7c. DATE PRONOUNCED DEAD

10/28 19 87

4:10 P. M

Female

White

Jun. 11, 1912

75 YRS

MONTHS

DAYS

HOURS

MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington D.C.

7b. CITIZENSHIP WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10 CITY OR TOWN OF DEATH

Silver Spring

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1131 University Boulevard West, #1017

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Clerk

12b. INDUSTRY OR BUSINESS

Federal Gov't

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1131 University Boulevard West, #1017

14 FATHER'S NAME

Louis

15 MOTHER'S MAIDEN NAME

G.

16 BUSHLOW

Anna

17 INFORMANT

6404 Park Hall Drive

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16b. SOCIAL SECURITY NO.

216-44-6817

17 INFORMANT

Barry Brodsky, Laurel, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

None

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

None

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

M.D.

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED 10/29/87

EXAMINER'S NAME (TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS, Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

10/30/1987

23c. NAME OF CEMETERY OR CREMATORY

Beth Shalom Congregation

23d. LOCATION

Capitol Prince Georges Maryland

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME

232 CARROLL STREET, N.W., WASHINGTON, D.C.

25a. DATE REC'D BY REGISTRAR

NOV 02 1987

25b. REGISTRAR'S SIGNATURE

me [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPACES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
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069487 OCT 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) Almeda D. Brown				2a. DATE OF DEATH MONTH DAY YEAR 10-14-87				2b. HOUR 9 38 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 11, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73		7 IF UNDER 1 YEAR MONTHS YEARS YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12325 Charles Road 20906	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Dodson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Fronie Simpson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b SOCIAL SECURITY NO. 213-38-2864		17 INFORMANT Robert Brown (son)				ADDRESS 14813 Lake Terrace Rockville, Md. 20853			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intestines ischemic and necrosis hours DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mesenteric artery thrombosis hours DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic vascular disease years									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: arteriosclerotic cerebral vascular disease and heart disease									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 1979 19 to 10-14-87 19 that (I) (we) last saw the deceased alive on 10-14-87 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Jeremy V. Cooke				DEGREE MD				22c DATE SIGNED 10/14/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Cooke				22e ADDRESS 10400 Conn Ave. Kensington, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/17/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		23e DATE REC'D. BY REGISTRAR OCT 21 1987	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a DATE REC'D. BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE John F. Gordon-Randall			

BP

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100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DECEASED NAME FIRST MIDDLE LAST RUSSELL M. BROWN		OCTOBER 31, 1987		12:30AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 23, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Graphic Designer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Lee Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Adela Carrick		13e. STREET ADDRESS / ZIP CODE 15301 Beaverbrook Court, #2G 20906	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-42-4857		17. INFORMANT ADDRESS Mrs. Barbara B. Leighton, Daughter, 8809 Burdette Road, Bethesda, MD. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Pulmonary Arrest</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Staph & E. coli Sepsis</i>					<i>1 week</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia, & Urinary tract inf.</i>					<i>1 week</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <i>Portulacaria Disease, Alzheimers, Neurologic deficit lower Extremities</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>Oct 24</i> 19 <i>87</i> to <i>Oct 31</i> 19 <i>87</i> that (I) (we) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Oliver J. Lawless MD</i>		DEGREE		22c. DATE SIGNED <i>10/31/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>OLIVER J. LAWLESS</i>		22e. ADDRESS <i>3501 International Drive Silver Spring</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE November 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN Suitland		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR NOV 2 1987		25b. REGISTRAR'S SIGNATURE <i>Frederick P. Jones</i>	

DHMH - 16 60M 7-84

(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 alleges any injury, or other traumatic event, the medical examiner must be notified of this.

070208 NOV-80

NOV 8 1980

068211 OCT-9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Virginia Lee Browne</u>			2a DATE OF DEATH MONTH DAY YEAR <u>10 5 87</u>			2b HOUR <u>3:10 PM</u>				
3 SEX <u>Female</u>		4 RACE <u>Black</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>June 6, 1933</u>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <u>54</u>		7b UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <u>54</u>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b CITIZEN OF WHAT COUNTRY? <u>United States</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.				
10 CITY OR TOWN OF DEATH <u>Gaithersburg</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHADY GROVE ADVENTIST HOSPITAL</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Deputy Director</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Social Services</u>				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>			13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Bethesda</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>8212 Stone Trail Drive, 20817</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>James Oscar Lee</u>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alice Worsham</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <u>123-26-9933</u>		17 INFORMANT <u>David A. Browne</u>		ADDRESS <u>8212 Stone Trail Dr. Bethesda, Md.</u>				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Hepatic Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Metastatic Colorectal Cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH10 weeks

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) the hospital attended the deceased from <u>7 Oct.</u> 19 <u>87</u> to <u>5 Oct.</u> 19 <u>87</u> that (1) <u>yes</u> I saw the deceased alive on <u>5 Oct.</u> 19 <u>87</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above <u>yes</u> and that (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above <u>yes</u>							
22b SIGNATURE <u>Jeffrey M. Crane</u>				DEGREE <u>M.D.</u>		22c DATE SIGNED <u>5 Oct. 1987</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jeffrey M. Crane</u>				22e ADDRESS <u>Suite 271; 14801 Physicians Lane Rockville, Md. 20850</u>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>10/6/87</u>		23c NAME OF CEMETERY OR CREMATORY <u>J. Wm. Lee's Sons Co.</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>	
24 FUNERAL DIRECTOR NAME <u>McGuire Funeral Service, 7400 Georgia Ave. N.W.</u>				ADDRESS <u>Washington, DC</u>		25a DATE REC'D BY REGISTRAR <u>OCT-8 1987</u>	
				25b REGISTRAR'S SIGNATURE <u>Julia Tindall</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician, it should be detached for use on the burial transit permit. Then please remove it to the State Dept. of Health and Mental Hygiene prior to burial arrangements. IMPORTANT: If item 21 is marked as item 38, state any injury or other traumatic event, the medical examiner must be notified at once.

069463 OCT 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen E Bryan					2a DATE OF DEATH MONTH DAY YEAR 10-18-87		2b HOUR 6:02 PM		
3 SEX Female		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 1 23 22		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 10122 BROCK DRIVE 20903	
14 FATHER'S NAME FIRST MIDDLE LAST FRANCIS E. MUDD				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY H. RICE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 215-46-4864		17 INFORMANT ADDRESS ROBERT A. BRYAN/HUSBAND/SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF, <u>gastrointestinal carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF, <u>5 mos.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (a) (this hospital) attended the deceased from 9/25, 19 87, to 10/17, 19 87, that (b) (we) lost saw the deceased alive on 10/17, 19 87, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) we (did) (did not) view the body after death.									
22b SIGNATURE Milton Koch, M.D.				DEGREE M.D.				22c DATE SIGNED 10/18/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MILTON KOCH, M.D.				22e ADDRESS 2101 MEDICAL PARK DR. SILVER SPRING, MD. 20902					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 21, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				24 ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a DATE REC'D BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE John Davidson	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) ABNER PERCIVAL BURGESS				2a DATE OF DEATH MONTH DAY YEAR 10-29-1987				2b HOUR 02:40 M	
3 SEX M		4 RACE C		5 DATE OF BIRTH MONTH DAY YEAR DEC 20, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7 IF UNDER 1 YEAR IF UNDER 23 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery (S. Tolson Rd) MD			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIREMAN		12b KIND OF BUSINESS OR INDUSTRY D C GOV'T	
13a STATE MARYLAND				13b COUNTY PR GEORGE		13c CITY OR TOWN DISTRICT HTS		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE P BURGESS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN MAY DIPPLE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 578-30-4742		17 INFORMANT ADDRESS CATHERINE P BURGESS SAME AS #13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute left ventricular failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 or 6 days
Conditions, if any, which gave rise to immediate cause (b) Coronary ASD									10 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Respiratory failure, Aspiration pneumonia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 10-28-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (and not) view the body after death.									
22b SIGNATURE J.E. Colton MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10-28-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J.E. Colton				22e ADDRESS 431 University Blvd. E. Silver Spring, MD.					
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 31 OCT 1987		23c NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL		23d LOCATION CITY OR TOWN COUNTY STATE SUTLAND PG MD			
24 FUNERAL DIRECTOR NAME ROBERT E WILHELM FUNERAL HOME				ADDRESS SUTLAND, MD		25a DATE REC'D BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE
10/10/50

NAME

JOHN J. HENRY

10017-100-301

10017-100-301

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) NANCY ANN BURGOWNE			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-17-87		2b HOUR M 4:58a
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1953	6 AGE IN YEARS (LAST BIRTHDAY) 34 YRS.	IF UNDER 1 YR MONTHS DAYS 10-17-87	IF UNDER 24 HRS HOURS MIN 4:58a
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		10 CITY OR TOWN OF DEATH Bethesda			
11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b KIND OF BUSINESS OR INDUSTRY Advertising	
13a STATE Virginia		13b CITY OR TOWN Fairfax	13c STREET ADDRESS 3412 Park Hill Place/22030		
14 FATHER'S NAME FIRST MIDDLE LAST George Burgoyne		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Johnson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b SOCIAL SECURITY NO. 375-60-4696		17 INFORMANT ADDRESS David DeConcini, same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 8120 Multiple injuries IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:15a 10-17-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of auto/auto(s) head-on collision	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.		21f LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 270 1/2 mile S. old Georgetown Rd. Mont. Co. Maryland	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 10-18-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 19, 1987		23c NAME OF CEMETERY OR CREMATORY Montgomery Crematorium	
23d LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland		24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814			
25a DATE REC'D BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE <i>John R. Linder</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29503
20 DATE OF DEATH MONTH DAY YEAR 2b HOUR
10-27-1987 9 PM

1 DECEASED NAME (TYPE OR PRINT) THOMAS F. BURKE		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02-10-97		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS
7a BIRTHPLACE STATE OR FOREIGN Mass.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10 CITY OR TOWN OF DEATH SILVERSPRING MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL NS CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER	
12b KIND OF BUSINESS OR INDUSTRY Pvt. Practice		13a STATE WASH. DC.		
13b COUNTY ---		13c CITY OR TOWN WASH. DC.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John Edmund Burke		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia --- Moakley		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b SOCIAL SECURITY NO. 579-52-4040A		
17 INFORMANT Loretta Johns, Silver Spring, MD		18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Brain Syndrome due to Cerebral Arteriosclerosis				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART I FOR PART 2)		
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from Aug 15 19 75 to Oct 27 19 87 that (I) (we) last saw the deceased alive on Oct 17 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		
22b SIGNATURE J. Neill Kennedy, MD.		22c DATE SIGNED 10/27/87		22d ADDRESS 145-19th St. N.W., Wash. D.C. 20036
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11/2/87		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
23d LOCATION CITY OR TOWN COUNTY STATE Lynn, Mass.		24 FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		
25a DATE REC'D BY REGISTRAR NOV 06 1987		25b REGISTRAR'S SIGNATURE J. Neill Kennedy		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

150-1000 B. A. I. V. D.

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Index

58/5/11

St. Mary's Cemetery

• 5549, 1000, 1

JOSEPH W. BAKER, JR.

69 1987 OCT 20

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) CHARLES RUSSELL BURRISS			2a DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 7 1987			2b HOUR A <input checked="" type="checkbox"/> M <input type="checkbox"/> A			
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 07 04 03	6 AGE (IN YEARS) (LAST BIRTHDAY) YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> 84 YRS	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 7 1987			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY			
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12902 TWINBROOK PKWY			12a USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE) Disabled		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD		13b COUNTY MONTGOMERY		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 20851 12902 TWINBROOK PKWY	
14 FATHER'S NAME FIRST Benjamin MIDDLE Burriss LAST Burriss				15 MOTHER'S MAIDEN NAME FIRST Annie E. MIDDLE Thomas LAST Thomas					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-76-5225		17 INFORMANT ADDRESS 19 Mathis Rosie Wood (sister) Rockville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDIST									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.									
19a DATE OF OPERATION —			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? —				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11 P.M. 10 7 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND IN BED				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f LOCATION STREET 12902 TWINBROOK PKWY CITY OR TOWN Rockville COUNTY MONTGOMERY STATE MD				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE Francis C. Mayle			TITLE (SPECIFY) DEPT			DATE SIGNED 10/7/87			
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYLE			ADDRESS 3200 WISCONSIN AVE BETHESDA MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-9-87		23c NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d LOCATION CITY OR TOWN Rockville COUNTY MD STATE MD		
24 FUNERAL DIRECTOR NAME George R. Snowden ADDRESS Rockville, MD 20850			25a DATE REC'D BY REGISTRAR OCT 13 1987			25b REGISTRAR'S SIGNATURE John D. ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH-17
(VR A15 ME (1))

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069136 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ANNE M BURROUGHS				2a DATE OF DEATH MONTH DAY YEAR 10-10-87				2b HOUR 8:45 AM	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 12 03		6 AGE (IN YEARS LAST BIRTHDAY) 84 83		7b HOUR MONTHS DAY HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH SANDY SPRING, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIENDS NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Typist		12b KIND OF BUSINESS OR INDUSTRY Retired State Dept.	
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 16300 Quaker Lane 20904	
14 FATHER'S NAME FIRST MIDDLE LAST S McEIVEN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA CLANTON		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) n/a					
16b SOCIAL SECURITY NO. 577-20-2722A		17 INFORMANT Jack Burroughs Laurel, Md. 20707							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: congestive heart failure									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 1979 19 10 19 87 that (1) (we) last saw the deceased alive on Oct 8 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we) (did) (did not) view the body after death.									
22b SIGNATURE Edward P. Taubman				DEGREE MD				22c DATE SIGNED 10/11/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Taubman				22e ADDRESS 1814 Panko Plaza Dr. Olney, Md. 20831					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/13/87		23c NAME OF CEMETERY OR CREMATORY Nirbeck Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Olney Montgomery Md.			
24 FUNERAL DIRECTOR NAME ADDRESS FLECK'S FUNERAL HOME LAUREL MD				25a DATE REC'D. BY REGISTRAR OCT 19 1987					
				25b REGISTRAR'S SIGNATURE Julia Simon-Rubell					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADOLPHE MARCEL CADEAUX			2a DATE OF DEATH MONTH DAY YEAR 10 25 87		2b HOUR 2:10 A
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR AUGUST 2, 1904	6 AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR IF UNDER 1 HR MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MORROCO	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUSINESS OWNER	12b KIND OF BUSINESS OR INDUSTRY HAIR PRODUCTS	
13a STATE D.C.	13b COUNTY -----	13c CITY OR TOWN WASHINGTON DC	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4200 CATHEDRAL AVE #804 (20016)	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB CADEAUX		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL AZOULAY			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 054-05-9874	17 INFORMANT (SON) JACK CADEAUX; 3015 IDAHO AVE., NW, #124 WASHINGTON, D.C. 20016		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) End Stage Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Arteriosclerotic vascular Disease, Congestive Heart Failure					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/25 87 4/10 to 10/25 19 87 that (I) (we) last saw the deceased alive on 10/25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b SIGNATURE Merlyn Vemury MD		DEGREE MD		22c DATE SIGNED 10/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MERLYN VEMURY MD		22e ADDRESS HEBREW HOME OF GREATER WASHINGTON			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10/26/87	23c NAME OF CEMETERY OR CREMATORY MT. LEBANON	23d LOCATION CITY OR TOWN COUNTY STATE ADELPHI PG MARYLAND		
24 FUNERAL HOME OR CHAPEL (NAME) DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.			25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 28 1987		
1170 ROCKVILLE PIKE; ROCKVILLE, MD 20852					

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067893 OCT-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked accident, 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

RELEASED BY ME

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AKA MARIE CAHILL 1. SISTER EDWARD MARIE CAHILL, C.S.C.				2a. DATE OF DEATH MONTH DAY YEAR 10/02/87			
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR 09/23/06		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTH DAY HOUR MIN 81 5:13 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NUN		12b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN KENSINGTON				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 5000 STRATHMORE AVE/20895			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD CAHILL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DILLION		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO 202-38-6293		17. INFORMANT SUPERIOR SISTER CATHERINE LASH SAME AS 13				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intense acute Hypertension/Hypertensive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> ALL WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 19 87 to 10/2/87 that we saw the deceased alive on 19 87, and that in my opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. [Signature]		22e. ADDRESS 9711 Medical Center Dr. Rockville MD 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR OCT 07 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

167893 OCT-8-07

RECEIVED
OCT 10 1907
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the application for a patent for the invention of a new and improved method of producing artificial silk from the waste of the silk rearing process. The same has been forwarded to the proper authorities for their consideration.

OCT 07 1907

069267 OCT 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29008

REG NO

1 DECEASED NAME (TYPE OR PRINT) Walter			FIRST MIDDLE LAST Camp			2a DATE OF DEATH MONTH DAY YEAR Oct. 18 87		2b HOUR 4 20 pm		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 5 / 19 / 04		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hamburg, Germany		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Sandy Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant-Self		12b KIND OF BUSINESS OR INDUSTRY Employed		
13a STATE MD			13b COUNTY Montgomery		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 17320 Quaker Lane B-4 Sandy Spring Md 20860	
14 FATHER'S NAME FIRST MIDDLE LAST AUGUST 1 KAMPE			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES WILL							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK			16b SOCIAL SECURITY NO 577-10-4481		17 INFORMANT ADDRESS Frieda M. Camp (Wife) Same as 13E					

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiomyopathy aneur

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10/18

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

b) **Phenemacin****10/18**

DUE TO, OR AS A CONSEQUENCE OF

c) **CAO****86**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Malady

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
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22a I certify that (I) (this hospital) attended the deceased from **10/17** 19 **87** to **10/18** 19 **87**, that (I) (we) last saw the deceased alive on **10/17** 19 **87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.

22b SIGNATURE [Signature]	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/18/87
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22d PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Schenck Gold	22e ADDRESS 18111 Prince Philip Dr Olney Md 20832
---	--

23a BURIAL CREMATION REMOVAL (SPECIFY) Cremation	23b DATE 10/19/87	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alex. Va.	23d LOCATION CITY OR TOWN COUNTY STATE
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24 FUNERAL DIRECTOR NAME H. Rinaldo	ADDRESS 11800 New Hampshire Ave.	25a DATE REC'D BY REGISTRAR OCT 20 1987	25b REGISTRAR'S SIGNATURE [Signature]
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10-18-70 10:50-00

RECEIVED

NOV 11 1970

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

OCT 30 1970

Released By *D. Miller M.F.*

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that information indicate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST ROBERT B. CAMPBELL				2a. DATE OF DEATH MONTH DAY YEAR 10/15/87		2b. HOUR 1043 am	
3. SEX male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 10/03/17		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CNTY BETHESDA MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Treasurer	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Miller Campbell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Brittain		13e. STREET ADDRESS / ZIP CODE 9211 Villa Drive 20817			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II 579-07-2696		17. INFORMANT ADDRESS Lois S. Campbell (wife) same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b). CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 15 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 79 to 10/15 19 87 that (I) (we) last saw the deceased alive on 10/15 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <i>Lewis C. Lipson, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS C. LIPSON, MD				22e. ADDRESS 5530 Wisconsin Ave. #505 Chevy Chase, Maryland 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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OCT 21 87

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG NO

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(PRINT)

William

Andrew

Carter

2a DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR 10/15 19 87 2b HOUR M

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

MAY 23 1936

6 AGE (IN YEARS)

51 YRS.

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE PRONOUNCED DEAD

MONTH DAY YEAR 10/15 19 87

24 HOUR P. M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

VIRGINIA

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10 CITY OR TOWN OF DEATH

Silver Spring

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1707 Hampshire Green Lane, #32

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

LABORER

12b KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET ADDRESS

1707 Hampshire Green Lane, #32

14 FATHER'S NAME

WESLEY

MIDDLE

LAST

CARTER

15 MOTHER'S MAIDEN NAME

LUCY

MIDDLE

LAST

SMITH

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

YES

(IF YES, GIVE WAR OR DATES)

WW II

16b SOCIAL SECURITY NO.

223-42-0387

17 INFORMANT

ANGELA STROUD

ADDRESS

SAME AS #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease.

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) _____

DUETO, OR AS A CONSEQUENCE OF

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a DATE OF OPERATION

None

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

None

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE:

TITLE (SPECIFY)

M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 10/15/87

EXAMINER'S NAME

John S. Rogers, M.D.

ADDRESS

1919 Seminary Road
Silver Spring, Montgomery County, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

SEPT. 22, 1987

23c NAME OF CEMETERY OR CREMATORY

MAIN UNO BAPTIST CHURCH CEM.

23d LOCATION

CITY OR TOWN

COUNTY

STATE

UNO, VIRGINIA

24 FUNERAL DIRECTOR

NAME

ADDRESS

CHAMBERS FUNERAL HOME - SILVER SPRING, MARYLAND

25a DATE REC'D BY REGISTRAR

OCT 23 1987

25b REGISTRAR'S SIGNATURE

[Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

87-84

25A

BP

DHMH - 17

(VR A15 ME (5))

000000000000

William

Andrew

Arthur

1905

67

Male

Black

1905

67

Montgomery County

Silver Spring

1707 Hampshire Green Lane, 255

Maryland

Montgomery

Silver Spring

1707 Hampshire Green Lane, 255

Acute myocardial infarction.

None

None

None

John A. Hoken, M.D.

Silver Spring, Montgomery County, MD

1907 January 1907

1907 67

001 43 800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must postmortem examine the body.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

2 DECEASED NAME (TYPE OR PRINT) John A. Casey			3 DATE OF DEATH MONTH DAY YEAR 10-17-87			2b HOUR 8:50 A.M.					
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 11 14 18		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN) PENNA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY			10 MD.		
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bal Pre Heart Care Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. AIR FORCE		12b KIND OF BUSINESS OR INDUSTRY RETIRED			
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15101 INTERLACHEN DRIVE 20906		
14 FATHER'S NAME ANTHONY CASEY				15 MOTHER'S MAIDEN NAME KATHERINE CYBUL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 189-05-0334		17 INFORMANT ISABEL CASEY			ADDRESS SAME AS 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Trauma COPS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 1987 to Oct 1987 that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]					DEGREE MD			22c. DATE SIGNED 10/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. CSOTH LERAGUL					22e. ADDRESS 7425 Arlington Rd, Belts, MD, 20705						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE OCT. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY ALEXANDRIA			23d. LOCATION COUNTY VA.			
24 FUNERAL DIRECTOR FRANCIS J. COLLINS, JR. WEST, SILVER SPRING, MD. 20901					25. DATE REC'D BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE John Gordon-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medicolegal examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29872

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice E. Cash			2a DATE OF DEATH MONTH DAY YEAR October 19, 1987		2b HOUR 7:00AM
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 18, 1901		6 AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS	7 UNDER 1 YEAR MONTHS YEARS MONTHS DAYS
7a BIRTHPLACE (COUNTRY) Kansas	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18801 Walker Choice Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Nesmith		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Washburn			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 527-72-2943		17 INFORMANT ADDRESS 9 Butterwick Court Margaret M. Marchese Gaithersburg, MD 20879	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Endometrial Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from <u>July</u> 19 <u>87</u> to <u>October 19</u> 19 <u>87</u> that (1) the last saw the deceased alive on <u>August 13</u> 19 <u>87</u> and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (1) my <u>did not</u> view the body after death.					
22b SIGNATURE <u>Jules R. Lodish, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED Oct. 19, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jules R. Lodish, M.D.				22e ADDRESS 2901 Olney-Sandy Spring Road Olney, Maryland 20832	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE October 19, 1987	23c NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Glendale, California
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a DATE REC'D. BY REGISTRAR OCT 26 1987 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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069032 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low register that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been used by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Judith Anne Castaldo			2a DATE OF DEATH MONTH DAY YEAR October 13, 1987		2b HOUR 3 A M
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR March 5, 1945		6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14601 Pommel Drive		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b KIND OF BUSINESS OR INDUSTRY Statistical Data	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Robert Lavender			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Rice		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-44-3177		17 INFORMANT ADDRESS Thomas J. Castaldo 14601 Pommel Drive Rockville, Maryland 20850	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>86</u> , to <u>Oct. 8</u> , 19 <u>87</u> , that (2) (we) lost saw the deceased alive on <u>October 8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Jeffrey M. Crane</u>		DEGREE MD		22c DATE SIGNED 10/13/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY M. CRANE M.D.		22e ADDRESS 1480 Physicians Lane Suite 271 Rockville, MD 20850			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE October 17, 1987	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey		FURNERAL HOME/ Rockville, Inc.		25a REC'D BY REGISTRAR OCT 16 1987	
300 West Montgomery Avenue		Rockville, Maryland 20850		25b REGISTRAR'S SIGNATURE <u>Julia Denson-Pudis</u>	

069172 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy			FIRST MIDDLE LAST Cavanaugh			2a. DATE OF DEATH MONTH DAY YEAR 9.29.87.			2b. HOUR 7:59 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS			IF UNDER 1 YEAR MONTHS DAY HOURS MIN. 7:59 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Glen Echo		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 31 Wellesley Circle				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Glen Echo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 31 Wellesley Cir./20812		
4. FATHER'S NAME FIRST MIDDLE LAST Floyd J. Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie E. Liddy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 577-28-7635		
17. INFORMANT ADDRESS Margaret M. Sieber, Same address as #13.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia, hypoproteinemia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9.29.87			21g. DATE SIGNED 9.30.87		
22a. I certify that (I) (this hospital) attended the deceased from 6.11.87 19 87 to 9.29 19 87 that I (we) last saw the deceased alive on 6.29 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Saulius Naujokaitis, MD						DEGREE MD			22c. DATE SIGNED 9.30.87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Saulius Naujokaitis, M.D.						22e. ADDRESS 3301 NM Ave. NW Wash, DC 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/2/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.						25a. DATE REC'D. BY REGISTRAR OCT 16 1987			25b. REGISTRAR'S SIGNATURE Julia Fowler-Randall		
ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016											

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dr. Mayle, NEO, Notified and approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and cause of death is not related to it, be notified if one.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1- STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST NIKOLAS CHALTOUPIS										2a DATE OF DEATH MONTH DAY YEAR OCTOBER 2, 1987		2b HOUR 9:32 PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR OCTOBER 14, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7 UNDER 1 YEAR MONTHS DAYS 57 YRS		8 UNDER 1 HR. HOURS MIN. 57 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b CITIZEN OF WHAT COUNTRY? GREECE		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.							
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Servant		12b KIND OF BUSINESS OR INDUSTRY Greek Govt.					
13a STATE Greece		13b COUNTY LAMIA		13c CITY OR TOWN LAMIA		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE LEFKADOS 13 99999					
14 FATHER'S NAME FIRST MIDDLE LAST Ioanis Chaltoupis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Despina Anastasiou									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO. ID 700-806		17 INFORMANT ADDRESS MRS. IRENE CHALTOUPIS (SAME AS DECEASED)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) CUSHING'S DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a DATE OF OPERATION 9/29/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Pituitary Microadenoma				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 31, 19 87 to OCTOBER 2, 19 87 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 2, 19 87 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not autopsy the body after death.													
22b SIGNATURE <i>Alan Vaw Deruoy</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 10/3/87					
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALAN VAW DERUOY				22e ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE 10-6-87		23c NAME OF CEMETERY OR CREMATORY Irene Chaltoupis		23d LOCATION CITY OR TOWN COUNTY STATE Lamia Greece							
24 FUNERAL DIRECTOR NAME ADDRESS Marshall's Funeral Home 4217 9th St NW: Washington, D.C.						25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE <i>Jana Anderson</i>					

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069585 OCT 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Edythe Bruce CHAMBERS			2a. DATE OF DEATH MONTH DAY YEAR OCT 17 87			2b. HOUR 0245A		
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 23, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 12 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) New Jersey	7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas L. Bruce			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam Thomas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 137-20-5190A		17. INFORMANT ADDRESS Mr. Steward W. Chambers Hagerstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) cardiac embolus DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 16 OCT 19 87 to 17 OCT 19 87 that (I) (we) last saw the deceased alive on 17 OCT 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Dennis J. Donohue						DEGREE MD		22c. DATE SIGNED 17 OCT 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis J. Donohue				22e. ADDRESS 7600 Carroll Ave Takoma Pk Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 20, 87		23c. NAME OF CEMETERY OR CREMATORY Marcella Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marcella Morris N.J.		
24. FUNERAL DIRECTOR NAME Davis Funeral Home				25a. DATE RECD. BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BEULAH M CHASE			2a DATE OF DEATH MONTH DAY YEAR OCT 11 1987		2b HOUR 3:59 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS
7a BIRTHPLACE (COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Burdette		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Melvina Bellison		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 463-24-2300
17 INFORMANT ADDRESS 9709 Dublin Rd.		17b SOCIAL SECURITY NO. 463-24-2300		17c NAME Hazel L. Mullinix, Walkersville, Md.		17d ADDRESS 9709 Dublin Rd.
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Cardiac Arrhythmias DUE TO, OR AS A CONSEQUENCE OF (c) Acute Bacterial Septicemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Failure						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 10/11/87 19 87 to 10/11/87 19 87 that (I) (we) last saw the deceased alive on 10/11/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death						
22b SIGNATURE Helen D. Khoury		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) HIRSH D. KHOURY		22e ADDRESS 20428 Germantown Rd, Germantown MD 20874				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 13, 1987		23c NAME OF CEMETERY OR CREMATORY Westview		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24 FUNERAL DIRECTOR Olin L. Molesworth, P.A.				25a DATE REC'D. BY REGISTRAR OCT 15 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be issued within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and signed and sealed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to perform an autopsy.

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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

87

29878

REG. NO.

 FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE CHOTKIN			2a. DATE OF DEATH MONTH DAY YEAR 10 4 87		2b. HOUR 0716 M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 9 09	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF BUSINESS OR KIND OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Montgom	13c. CITY OR TOWN gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST DAVID LEVIN		15. MOTHER'S MAIDEN NAME MIDDLE LAST SARAH SAFTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 096-52-3871	17. INFORMANT ADDRESS Husband (same)		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypotension, intra-abdominal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) ruptured abdominal aortic aneurysm					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 10/7/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aortic Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/7 19 87 to 10/7 19 87 that (I) (we) last saw the deceased alive on 10/7 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert L. Fox MD		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED 10/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Fox MD		22e. ADDRESS 1811 Prince Philip Dr. Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/9/87	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GDN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA
24. FUNERAL DIRECTOR'S NAME 1170 DANZANSKY-GOLDBERG MEMORIAL CHAPELS ROCKVILLE PIKE, ROCKVILLE, MD 20852			25a. DATE REC'D. BY REGISTRAR OCT 13 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the following papers: Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked (b) 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29380

REG NO

1 DECEASED NAME (TYPE OR PRINT) Ruth M. Clausman			2a DATE OF DEATH MONTH DAY YEAR 10/1/87		2b HOUR 123 P.M.
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR February 14, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Off.	12b KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Potomac	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME Charles S. Clausman		15 MOTHER'S MAIDEN NAME Florence E. Cox		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO Not Available		17 INFORMANT Robert E. Clausman		17a ADDRESS 1705 York Road Colony Park, Reading, PA. 19610	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 36 hours 25 yrs
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10/1/87 to 10/9/87 that (I) (we) last saw the deceased alive on 10/9/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE M. S. Kanovsky		DEGREE MD	22c DATE SIGNED 10/9/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN S. KANOVSKY, M.D.		22e ADDRESS 5401 Western Avenue, N.W. Washington, D.C. 20015	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE (SPECIFY) October 13, 1987	23c NAME OF CEMETERY OR CREMATORY Gethsemane Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Muhlenberg Berks Pennsylvania
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7555 Wisconsin Ave. Bethesda, Maryland 20814		25a DATE REC'D BY REGISTRAR OCT 14 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29881

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eleanor A. Coffin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>October 20, 1987</i>		2b. HOUR <i>9:20</i> a. m.		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>October 14, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>65 YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>15107 Interlachen Drive 308</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>VERNON E. WHITE</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELBA ROMBERGER</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>218-16-8196</i>		17. INFORMANT <i>SON</i>		ADDRESS <i>3836 WALT ANN DR.</i>		EDWIN R. ANTHONY, III/ELLICOTT CITY, MD 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>End stage lung disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Lung mass & possible Brain Metastasis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <i>(1) Lung Mass (2) Severe COPD (3) Pneumonia (4) Anemia (5) Renal Failure</i>							
19a. DATE OF OPERATION <i>NIA</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> 19 <i>87</i> to <i>10/20</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>10/19</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ravi Passi</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>10/20/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ravi Passi, M.D.</i>				22e. ADDRESS <i>14812 Physicians Lane #261 Rockville, MD 20850</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>OCT 23, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATL CEM</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ARLINGTON VIRGINIA</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 29 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Sanders-Randall</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

29382

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULUS H COHEN			2a DATE OF DEATH MONTH DAY YEAR 10 12 87			2b HOUR 2:48 PM	
3 SEX MALE		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR 7 14 91		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DESIGNER		12b BUSINESS OR INDUSTRY DRESSES	
13a STATE MARYLAND				13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING	
14 FATHER'S NAME FIRST MIDDLE LAST JONAH COHEN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA GLASER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 109-07-9555		17 INFORMANT ADDRESS SILVER SPRING, MD. ABNER B. COHEN, 1136 LOXFORD TERRACE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Aortic Regurgitation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Atrial Fibrillation							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 10313 Georgia Ave Silver Spring Md 20902			
22a I certify that (I) (this hospital) attended the deceased from 10/9/87 to 10/12/87 that I (we) last saw the deceased alive on 10/12/87 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.							
22b SIGNATURE Herman B Segal				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/13/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Herman B Segal				22e ADDRESS Silver Spring Md 20902			
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 10/14/1987		23c NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d LOCATION (OR TO) FALLS CHURCH, VIRGINIA	
24 FUNERAL DIRECTOR NAME DONALD W. STEIN ADDRESS HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE Julius Davidson-Randall	

MEDICAL CERTIFICATION

72
68
55
42
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

068553 OCT 14 87

DIVISION OF VITAL RECORDS, 201 W. PULSTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 72 RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PULSTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29883

1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) EFFIE M. COMBS		2a DATE KNOWN OF DEATH ESTIMATED Oct 9, 1987		2b HOUR 5:30	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR JUNE 22, 1900 27 YRS	6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN	IF UNDER 1 YR	IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH St. Louis		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a USUAL OCCUPATION (TYPE OF WORK) Homemaker	
13a STATE MD		13b COUNTY Mont.		13c CITY OR TOWN St. Louis	
14 FATHER'S NAME FIRST MIDDLE LAST Mahlon L. Bean		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Florence Brown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. 217-44-3113		17 INFORMANT ADDRESS Cleland W. Combs-husband- (same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last (b) Fracture Rt Hip DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None					
19a DATE OF OPERATION 10/6/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt. Hip		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:10-4 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall at home	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY FARM, ETC.) Home		21f LOCATION CITY OR TOWN COUNTY STATE St. Louis Mont. Md.	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John S. Rogers, DME		TITLE (SPECIFY) Dep.		MEDICAL EXAMINER DATE SIGNED Oct 14 1987	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Rd., S.S. Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-13-87		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		25a DATE REC'D. BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE Julia Tisdale	
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.N. Ave., Silver Spring, Md.					

07/84
25MBP
DHMH 17
(VR A15 ME (5))

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REBIA NOTCOO 61819



10067894

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20004

REG. NO.

1- FOR STATE REGISTRY 1 DECEASED NAME (TYPE OR PRINT) Joseph Clay Combs		FIRST MIDDLE LAST		2a DATE KNOWN OF DEATH ESTI MATED 00 Oct 19 87		2b DATE OF DEATH MONTH DAY YEAR		2c DATE PRONOUNCED DEAD Oct 2 19 87		2d HOUR MIN	
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR Nov 21 19 18	6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 68 YRS	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Sil Spg		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1605 Sanford Rd		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b KIND OF BUSINESS OR INDUSTRY DEPT OF AGRICULTURE		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
13a STATE MD		13b COUNTY Mont.		13c CITY OR TOWN Sil Spg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1605 Sanford Rd			
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH C. COMBS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARTON		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-44-0327		17 INFORMANT SON		ADDRESS 15316 DELPHINUM ROCKVILLE, MD 20853	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None											
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER				DATE SIGNED Oct 3 19 87			
EXAMINER'S NAME (TYPE OR PRINT) JOHN ROGERS		ADDRESS SEMINARY ROAD SILVER SPRING, MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 7, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING MONTGOMERY MD				23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a DATE REC'D BY REGISTRAR OCT 07 1987		25b REGISTRAR'S SIGNATURE John Rogers			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-1, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

007004 OCT-001

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the main body of the page.]

OCT 07 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theron E. Condon		2a. DATE OF DEATH MONTH 10 DAY 11 YEAR 87		2b. HOUR 11:15 P.M.	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DECEMBER DAY 6 YEAR 1911	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	7. IF UNDER 1 YEAR MONTHS 11 DAYS 87	8. IF UNDER 24 HRS. HOURS 11 MIN. 15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15410 BASSETT LANE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERV EXAMINER	12b. KIND OF BUSINESS OR INDUSTRY PATENT OFFICE		
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 15410 BASSETT LANE 20906	
14. FATHER'S NAME FIRST SAMUEL MIDDLE CONDON LAST CONDON	15. MOTHER'S MAIDEN NAME FIRST GRACE MIDDLE H. LAST COLBY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 140-09-5471	17. INFORMANT ADDRESS DOROTHEA Y. CONDON/WIFE/SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic adenocarcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease; Malignant Pericardial Effusion					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease; Malignant Pericardial Effusion					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (the hospital) attended the deceased from June 1987 to 10/11/87 , that (1) (was) last seen alive on 9/18/87 , and that in my (best) opinion death occurred on the date and hour and from the causes stated above; (2) (was) last seen alive on 9/18/87 , and that in my (best) opinion death occurred on the date and hour and from the causes stated above.					
22a. SIGNATURE Jules R. Lodish	DEGREE MD	22b. ADDRESS Sandy Spring Road Olney, Maryland		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules R. Lodish					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE OCT15, 1987	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	25a. DATE REC'D. BY REGISTRAR OCT 19 1987	25b. REGISTRAR'S SIGNATURE Jules R. Lodish			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

George

H

Cook

2a DATE OF DEATH

MONTH DAY YEAR

September 29, 1987

2b HOUR

M

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

MONTH

DAY

YEAR

2 / 8 15

6 AGE (IN YEARS LAST BIRTHDAY)

72

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10 CITY OR TOWN OF DEATH

Silver Spring

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

15414 Holly Grove Road

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b KIND OF BUSINESS OR INDUSTRY

WSSC

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

Montg.

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?

NO

13e STREET ADDRESS / ZIP CODE

15414 Holly Grove Rd/20904

14 FATHER'S NAME

Roland Cook

15 MOTHER'S MAIDEN NAME

Frances Cedric

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

WWII

17 INFORMANT

215-38-3431

18 ADDRESS

130 Awkard Lane
Silver Sp., MD 2090

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b)

PANCREATIC CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lastAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

9 Mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from Feb 19 87 to Oct 19 87 that (I) (we) last
saw the deceased alive on 28 Sept 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If I/we did not view the body after death)

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c DATE SIGNED

10/8/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

DONALD E DILLON, M.D.

22e ADDRESS

2901 Olney-Sandy Spring Rd. Olney, Md. 20832

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10-7-87

23c NAME OF CEMETERY OR CREMATORY

Ash Memorial Cem.

23d LOCATION
(CITY OR TOWN)

Sandy Spring, Montg, MD

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

George R. Snowden

ADDRESS

Rockville, MD 20850

25 DATE REC'D. BY REGISTRAR 26 REGISTRAR'S SIGNATURE

OCT 13 1987

Julia Anderson-Randall

K

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

068551 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) L JEAN COOMBS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 10, 1987		2b HOUR 3:35 PM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 2, 1946		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK, BUT MOST OF WORKING LIFE) Professor and Research Analyst		12b KIND OF BUSINESS OR INDUSTRY Georgetown University
13a STATE MARYLAND		13b COUNTY Baltimore	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Albert L. Coombs		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn E. Zimowski		13e STREET ADDRESS / ZIP CODE 9118 DEVIATION RD. 21236	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. N/A		17 INFORMANT ADDRESS MRS. CAROLYN COOMBS, MOTHER / #5, LACONIA, NH 03246	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LEIOMYOSARCOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 7 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>SEPTEMBER 29</u> 19 <u>87</u> to <u>OCTOBER 10</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 10</u> 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not see the body after death.					
22b SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stan L. Pkowitz		22e ADDRESS National Institutes of Health Beth., Md.			
23a BURIAL, CREMATION, REMOVAL Burial	23b DATE 10-14-1987	23c NAME OF CEMETERY OR CREMATORY Mt. Prospect Cemetery		23d LOCATION Amesbury Essex MA.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a DATE REC'D. BY REGISTRAR OCT 13 1987	
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed with the attending physician and completely filled in by the funeral director, page 3 should be submitted for use as the burial-transit permit. This permit is a separate carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary L. Corbin			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1987		2b. HOUR 5:25a.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 31, 1919		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		
14. FATHER'S NAME FIRST MIDDLE LAST Herbert H. Hodge		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Ferguson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-38-9755		17. INFORMANT William H. Corbin 4507 Traymore Street Bethesda, Maryland 20814 (Husband)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 YEARS</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>CHRONIC DEPENDENCE ON MECHANICAL VENTILATION</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART I. OR PART 2.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>29 DECEMBER 19 86</u> to <u>5 OCTOBER 19 87</u> , that (I) (we) last saw the deceased alive on <u>5 OCTOBER 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) move the body after death.						
22b. SIGNATURE <i>John E. Yergs II MD</i>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>5 OCTOBER 1987</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN E. YERGS II MD</u>		22e. ADDRESS <u>WASHINGTON CLINIC</u> <u>5401 WETTER AVE NW WASH DC 20015</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR OCT 09 1987				
		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068855 OCT 10 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DECEASED NAME (LAST OR PRINT) SAMUEL J. CORDEN		2b DATE OF DEATH MONTH 10 DAY 12 YEAR 87		2c HOUR 5:30 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH May DAY 14 YEAR 1922		6 AGE (IN YEARS LAST BIRTHDAY) 65
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE Maryland		13b COUNTY Howard	13c CITY OR TOWN Clarksville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 14070 A Brighten Dam Rd 21029
14 FATHER'S NAME FIRST Joseph MIDDLE Corden LAST		15 MOTHER'S MAIDEN NAME FIRST Charlotte MIDDLE Zolla LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW 11	17 INFORMANT Mrs Yolanda Corden		ADDRESS 14070A Brighten Dam Rd			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) POST NEUROTIC CORROSIS DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ESOPHAGEAL VARICEAL BLEEDING, RECURRING SEPTICEMIA, HEPATIC ENCEPHAL			
19a DATE OF OPERATION 10/6/87	19b CONDITION FOR WHICH OPERATION WAS PERFORMED INSERTION OF NEW DENVER SHUNT	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERWAY? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (a) (this hospital) attended the deceased from 12/9 19 87 to 10/12 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated.			
22b SIGNATURE Edwin Jackson		DEGREE: ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/12/87
22d PHYSICIAN'S HOME (IF DIFFERENT) Edwin Jackson		22e ADDRESS 5340 TEN OAKS RD CLARKSVILLE MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 16'87	23c NAME OF CEMETERY OR CREMATORY Mt Carmel	23d LOCATION CITY OR TOWN COUNTY STATE Jenner Cross Roads Pennsylvania
24 FUNERAL DIRECTOR HARRY H. WITZKE FUNERAL HOME INC		4112 OLD COLUMBIA PIKE ELLICOTT CITY MD 21043	25 DATE RECEIVED BY REGISTRAR OCT 15 1987
		25b REGISTRAR'S SIGNATURE Juanita D. Brown-Randall	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mac J. Coy</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 3 87</i>		2b. HOUR MIN <i>130 P M</i>	
3. SEX <i>F</i>		4. RACE <i>C I</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 31 97</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York USA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fernwood House</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clement Jacques</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret Souliere</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. SOCIAL SECURITY NO. <i>579-28-3588</i>		17. INFORMANT (Nephew) <i>Paul Desjardins. Haverford College, 19041</i>	
18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple massive Cerebral Infarcts</i> DUE TO, OR AS A CONSEQUENCE OF <i>with most recent, on 9/27/87</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <i>Hypertensivetherosclerotic</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cardiovascular Disease</i> (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>20 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>11/26</i> 19 <i>68</i> to <i>10/3</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>9/23</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (which) (deceased) view the body after death.						
22b. SIGNATURE <i>Michael M. Healy MD</i>				DEGREE		22c. DATE SIGNED <i>10/3/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael M. HEALY MD</i>				22e. ADDRESS <i>5652 Shields Dr. Bethesda MD 20817</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10-4-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>
24. FUNERAL DIRECTOR <i>J. William Lee's Sons Company</i> <i>300 4th St. N.E. Washington, D.C. 20002</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 05 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Sanders-Rudman</i>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) William Holly CRAIG		2a DATE OF DEATH MONTH DAY YEAR 10 2 87		2b HOUR 10 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1922	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a STATE Penna.		13b COUNTY York		13c CITY OR TOWN York	
14 FATHER'S NAME FIRST MIDDLE LAST William Payne Craig		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Holly		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2		16b SOCIAL SECURITY NO 045-18-3976		17 INFORMANT ADDRESS Jean Deardorff Craig, Item 13	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Right Cerebral Bleed DUE TO, OR AS A CONSEQUENCE OF Hemorrhagic Infarct hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Aneurysm minutes (c) Arteriosclerotic Aneurysm					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9/20 19 87 to 10/2 19 87 that (I) (we) last saw the deceased alive on 10/1/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b SIGNATURE Elisa J. MacPher MD		DEGREE MD		22c DATE SIGNED 10/2/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ELISA J. MACPHER MD		22e ADDRESS 8808 HIDDEN HILL LN - POKESVILLE, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b DATE Oct. 5, 1987		23c NAME OF CEMETERY OR CREMATORY Holy Saviour	
23d LOCATION CITY OR TOWN COUNTY STATE York York Pa.					
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.		25a DATE REC'D BY REGISTRAR OCT 06 1987			
25b REGISTRAR'S SIGNATURE Julia Davidson					

007522 OCT-78

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a series of lines or a list.]

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (LAST)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
REX		FREDERICK		CRAWFORD				OCTOBER 29, 1987				4:15p m	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR JUNE 14, 1948				39 YRS.				MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Michigan		USA						MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NIH, THE CLINICAL CENTER						Naval Officer (Ret) US Navy					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
MICHIGAN								BAY PORT		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Leland E. Crawford						FIRST MIDDLE LAST Helen Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT						ADDRESS	
Yes				365-48-1344		MRS. LUCY CRAWFORD (wife)						SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) CARDIAC AND RENAL FAILURE													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
b) METASTATIC RENAL CELL CARCINOMA													
DUE TO, OR AS A CONSEQUENCE OF													
c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 11, 19 87, to OCTOBER 29, 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 29, 19 87, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		22c. DATE SIGNED			
Louis Van der Molen, MD										10/30/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS					
Louis Van der Molen, MD								NATIONAL INSTITUTES OF HEALTH, CC. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Removal				11-2-87		Warren Juenger F/H				Sebewaing Michigan			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Marshall's Funeral Home NAME 4217 9th St NW: Washington, D.C. ADDRESS								NOV 04 1987		John Gordon-Rodger			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100335 NOV-281
050310 NOV-281

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ONE COPY

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

069986 OCT 28 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG NO	
1- STATE REGISTRAR										2- BASED NAME (OR PRINT)	
James William Creed										2a. DATE KNOWN OF DEATH ESTI MATED 10-21 1987	
3 SEX MALE 4 RACE WHITE 5 DATE OF BIRTH APRIL 27 1920 6 AGE 67 YRS 7 IF UNDER 1 YR 7a. DATE PRONOUNCED DEAD 10-22- 19 87 7b. HOUR 10:40										7c. DATE PRONOUNCED DEAD 10-22- 19 87 7d. HOUR 10:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA 7b. CITIZEN OF WHAT COUNTRY? U.S.A 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD											
10 CITY OR TOWN OF DEATH Takoma Park 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 7620 Maple Avenue 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE 12b. KIND OF BUSINESS OR INDUSTRY NURSING											
13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN TAKOMA PARK 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7620 MAPLE AVENUE 20912											
14 FATHER'S NAME JOHN A 15 MOTHER'S MAIDEN NAME ROSA GARWOOD											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 729-07-1675A 17 INFORMANT ETHEL L. ROBERTS, 11550 STEWART LN. S.E. MD											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural and Lower gastrointestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Alcoholic liver disease and coumadin therapy DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. aortic valve replacement										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 7d. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2)											
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Charles P. Kokes, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-23-87											
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Oct. 26. 1987 23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville md											
24. FUNERAL DIRECTOR (NAME) ADDRESS DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											

07/84
25M
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DHMH 17
(VR A15 ME (5))

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069204 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia CROWE			2a. DATE OF DEATH MONTH DAY YEAR OCT. 5, 87			2b. HOUR MIN. 7:50 P.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 29 93		6 AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HERITAGE Healthcare Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Med. Tech.		12b KIND OF BUSINESS OR INDUSTRY Ret. Adm.	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Takoma Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7525 Carroll Ave. 20912	
14 FATHER'S NAME FIRST MIDDLE LAST William Thomas Crowe		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara M. Roth		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b SOCIAL SECURITY NO. 579-58-1468		17 INFORMANT ADDRESS Merwin Crowe, 1015 Greenleaf, Wilmette, Ill.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) ARTERIOSCLEROTIC HEART Disease 10 yrs. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPOTHYROIDISM, CHRONIC PARTIAL INTESTINAL OBSTRUCTION.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (1) (the hospital) attended the deceased from 9/13/87 to OCT 5 1987 that (1) (was) lost saw the deceased alive on 9/13/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (did) (did not) view the body after death									
22b SIGNATURE William S. Miller M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM S. Miller M.D.		22e ADDRESS 4201-Conn. Ave N.W., WASH. D.C. 20008							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-9-87		23c NAME OF CEMETERY OR CREMATORY Fulton Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Fulton Kentucky		24 FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, 5130 Wis. Ave. N.W., Wash., D.C.	
25a DATE REC'D BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Lindner							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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William C. Brown, 1015 Greenleaf, Chicago, Ill.

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Kentucky

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM A CRUICKSHANK			2a. DATE OF DEATH MONTH DAY YEAR October 7, 1987		2b. HOUR 8:00^{PM}
3 SEX Male	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR August 19, 1927		6 AGE (IN YEARS LAST BIRTHDAY) 60	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, B.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) 101 Hutton Street 20877		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Project Cord.		12b KIND OF BUSINESS OR INDUSTRY Construction
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 101 Hutton St. 20877
14 FATHER'S NAME FIRST MIDDLE LAST William nmnm Cruickshank		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Wilhemina Vierbuchen			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. 215-20-4186		17 INFORMANT ADDRESS Jennie S. Cruickshank Same as #13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) Advanced Respiratory Failure with bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF } (c) Emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 1 yr. 3 yr.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Long Cancer with Right Pneumectomy and post-op. Emphysema					
19a DATE OF OPERATION 2-12-77		19b CONDITION FOR WHICH OPERATION WAS PERFORMED SQUAMOUS CELL CARCINOMA @ Lung		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b OR PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from Jan 23 19 87 to Oct 7 19 87 that (1) (we) last saw the deceased alive on Oct 7 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.					
22b SIGNATURE Frank J. Mayo		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-8-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FRANK J. MAYO		22e ADDRESS 1622a Frederick Rd. # 213 Gaithersburg, Md. 20877			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE October 9, 1987	23c NAME OF CEMETERY OR CREMATORY Balto./Wash. Crem.		23d LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G., Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a DATE REC'D. BY REGISTRAR OCT 15 1987			
		25b REGISTRAR'S SIGNATURE Lelia Gordon-Rendell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this and page 4 to the funeral home. The funeral home will forward this with the State Dept. of Health and Mental Hygiene prior to burial. A certificate of removal is not required for removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1001 130 747 13

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) DOROTHY M. CURRIER			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 3, 1987		2b HOUR 6:00P M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR MARCH 4 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12902 ESTELLE ROAD		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER	12b KIND OF BUSINESS OR INDUSTRY SOVRAN BANK	
13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN WHEATON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 12902 ESTELLE ROAD 20906	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN LEIZEAR		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE GROOMES			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215-20-3149	17 INFORMANT ADDRESS STEVEN R. CURRIER/SON/SAME AS 13			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) <u>Metastatic adenocarcinoma, unknown primary (7 months)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>MAR 30</u> 19 <u>87</u> to <u>SEPT</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>SEPT</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Jules R. Lodish, M.D.</u>		DEGREE <u>M.D.</u>		22c DATE SIGNED <u>10/5/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jules R. Lodish, M.D.</u>		22e ADDRESS <u>2201 Olney-Sandy Spring Rd. Olney, MD. 20832</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT6,1987	23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d LOCATION ROCKVILLE MONTGOMERY MARYLAND
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE REC'D. BY REGISTRAR OCT 07 1987		
			25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

067002 OCT-981

CHATELAIN PLANO

208 COTTON FIBER

OCT 04 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Mildred C. Dailey			2a DATE OF DEATH MONTH DAY YEAR 10/ 16/ 87			2b HOUR 4:30p M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 10 1903		6 AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Maryland		13b COUNTY Mont.		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3411 N. Hight St. 20832
14 FATHER'S NAME FIRST MIDDLE LAST Philip H. Ray			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Riggs					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-74-5887		17 INFORMANT ADDRESS Audrey Johnson, Burtonsville, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Colon Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>ASAD, Diabetes Mellitus</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>71</u> to <u>10-16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-16-87</u> 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>D. L. Anderson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/16/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Daniel L. Anderson, M. D.				22e ADDRESS 2901 Olney/Sandy Spring Rd., Olney, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct 19, 1987		23c NAME OF CEMETERY OR CREMATORY Colesville Cemetery		23d LOCATION CITY OR TOWN Colesville Mont. MD.		23e ZIP CODE 20832
24 FUNERAL DIRECTOR NAME ADDRESS Barber Funeral Home, Laytonsville, Md. 20879				25a DATE REC'D. BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <u>Daniel L. Anderson</u>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
JOHN ALOYSIUS DALY			OCTOBER 13, 1987			8:05A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 GENDER YEAR		
MALE	CAUCASIAN	FEBRUARY 24, 1939	48					
7a BIRTHPLACE	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
NEW JERSEY	USA				MONTGOMERY MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	2409 LAURELWOOD TERRACE		INSURANCE BROKER			SELF-EMPLOYED		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input type="checkbox"/> NO <input type="checkbox"/>			2409 LAURELWOOD TERRACE 20904		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
JOHN A. DALY			HELEN NIECHWIADOWICZ					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
YES			145-28-3566			DEANNA R. DALY/WIFE/SAME AS 13		
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Colon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 8 OR PART 9)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>October 1</u> 19 <u>86</u> to <u>Oct 13</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct 9</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>Thomas Sacks</u>						DEGREE M.D.		22c DATE SIGNED 10/13/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS SACKS						22e ADDRESS 2201 L STREET, NW WASHINGTON, DC		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
CREMATION			OCT 15, 1987		METROPOLITAN CREMATORY		ALEXANDRIA VIRGINIA	
24 FUNERAL DIRECTOR NAME						25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						OCT 19 1987 Julia Davidson-Pandey		

088155 OCT 10 1951



GREEN COTTON & CO.

WALKER & HILL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

Ernest Humphrey Daniel, Jr.

REG. NO.

2a BASED NAME
(PRINT)

Ernest Humphrey

FIRST

MIDDLE

LAST

Daniel, Jr.

2b DATE OF DEATH

MONTH

DAY

YEAR

2c HOUR

9/15/87 9:40 pm

3 SEX

Male

4 RACE

White

5 DATE OF BIRTH

MONTH

DAY

YEAR

02

08

08

6 AGE

(IN YEARS LAST BIRTHDAY)

79

YRS

7a BIRTHPLACE
(COUNTRY)

DC

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED

☒

NEVER MARRIED

☐

WIDOWED

☐

DIVORCED

☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD

10 CITY OR TOWN OF DEATH

Rockville

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Potomac Valley Hosp & Tr

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

General Mgr.

12b KIND OF BUSINESS OR INDUSTRY

Ice Cream Mfg.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

Mont.

13c CITY OR TOWN

Beth.

13d INSIDE CITY LIMITS?

YES

☒

NO

☐

13e STREET ADDRESS / ZIP CODE

5207 Albemarle

13f

St. 20816

14 FATHER'S NAME

FIRST

ERNEST

MIDDLE

HUMPHREY

LAST

DANIEL, SR

15 MOTHER'S MAIDEN NAME

FIRST

BERNICE

MIDDLE

LAST

ROWE

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)

WW II

16c

577-07-3075

17 INFORMANT

Helen B. Daniel Same as item # 13

ADDRESS

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Aspiration of oral secretions 3
with terminal pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Chronic obstructive Lung Disease
with Emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1-2 days

20 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Repeated cerebro-vascular accidents with brain stem infarction

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1921c HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 21b, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f LOCATION
(STREET)

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from May 1987 to September 1987 that I (we) last saw the deceased alive on September 5 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

22c DATE SIGNED

William O. Bailey, Jr., M.D.

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

9/15/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

William O. Bailey, Jr., M.D.

22e ADDRESS

2377 Devonshire Place, NW
Washington, DC 2000823a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

9/18/87

23c NAME OF CEMETERY OR CREMATORY

Christ Church Cem.

23d LOCATION
(CITY OR TOWN)

Irvington, VA

COUNTY

STATE

24 FUNERAL DIRECTOR

Joseph Gawler's Sons, Inc.

5130 WI Ave. NW Wash., DC 20016

25a DATE REC'D. BY REGISTRAR

SEP 23 1987

25b REGISTRAR'S SIGNATURE

Julia Gordon-Rudolf

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
PHILIP A. DARMODY			OCTOBER 25 1987			4:00P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
MALE	CAUCASIAN	MONTH DAY YEAR SEPT 8 1911	76 YRS			MONTHS DAYS HOURS MINS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
ILLINOIS	USA				MONTGOMERY MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING	110 WHITMOOR TERRACE			ELECTRICAL ENGINEER			F.A.A.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
13a STATE	13b COUNTY	13c CITY OR TOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			110 WHITMOOR TERRACE 20901		
MARYLAND	MONTGOMERY	SILVER SPRING						
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST GEORGE DARMODY			FIRST MIDDLE LAST SUSANNE HEIN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT		
YES			1942-1946			709-01-2286		
						BRIAN P. DARMODY		
						ADDRESS 18 DUNMORE ROAD CATONSVILLE, MD 21228		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>7 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus</i>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 19 83 to 19 87 that (I) (we) last saw the deceased alive on 9/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE						DEGREE		22c DATE SIGNED
<i>Daniel J. Boyle</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10/24/87
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS		
DR. DANIEL J. BOYLE						10313 GEORGIA AVENUE #201 SILVER SPRING, MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
BURIAL			OCT28,1987		GATE OF HEAVEN CEMETERY		SILVER SPRING MONTGOMERY MD	
24 FUNERAL DIRECTOR						25a DATE REC'D. BY REGISTRAR		
FRANCIS J. COLLINS, JR.						25b REGISTRAR'S SIGNATURE		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						OCT 29 1987		

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

Y O C E D A P 0 1 0 8

168504 OCT 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- DECEASED NAME (TYPE OR PRINT) Frank P. Davis										2a DATE KNOWN OF DEATH ESTIMATED Oct 5 1987		2b HOUR OF DEATH 2:30 PM			
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH 10 DAY 13 YEAR 1927		6 AGE (IN YEARS) LAST BIRTHDAY 60 YRS		IF UNDER 1 YR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Oct 5 1987		2d HOUR OF DEATH 2:30 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Healy Cross Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLAIMS ADJUSTER				12b KIND OF BUSINESS OR INDUSTRY JOHNSON & ADAMS AGENCY			
13a STATE MD				13b COUNTY Montgomery		13c CITY OR TOWN WHEATON		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 20902 2712 Avenue St					
14 FATHER'S NAME FIRST FRANK MIDDLE PELOUZE LAST DAVIS, SR.				15 MOTHER'S MAIDEN NAME FIRST ETHEL MIDDLE COLE LAST HUGHLETT											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 214-03-6167				17 INFORMANT ADDRESS ELIZABETH B. DAVIS/WIFE/SAME AS 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 8809 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Fracture C4-C5 DUE TO, OR AS A CONSEQUENCE OF (c) Fall down stairs after cardiac arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None															
19a DATE OF OPERATION None				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? —								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR 09 AM 24 MONTH 10 DAY 07 YEAR 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fall down stairs after cardiac arrest									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f LOCATION STREET Avenue St CITY OR TOWN Silver Spring COUNTY Montgomery STATE MD									
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Doc				MEDICAL EXAMINER John S. Rogers				DATE SIGNED Oct 8 1987			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS SEMINARY ROAD SILVER SPRING, MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE OCT8, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				23d LOCATION CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						25a DATE REC'D BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE John S. Rogers							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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OCT 13 1967

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) MARY ELIZABETH DECOURCEY			2a. DATE OF DEATH MONTH 10 DAY 15 YEAR 87		2b. HOUR 10:05 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH October DAY 21 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medical
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11528 Lovejoy Street 20902	
14. FATHER'S NAME FIRST Edward MIDDLE J. LAST DeCoursey		15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE E. LAST O'Malley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 026-32-9686		17. INFORMANT Friend Margaret H. Whittaker ADDRESS 11528 Lovejoy Street Silver Spring, Md. 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH CAUSED BY IMMEDIATE CAUSE (a) CARDIAC arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 4 87 to present 19 83 that (I) (we) lost saw the deceased alive on Oct 4 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Merendino		DEGREE MD		22c. DATE SIGNED 10/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MERENDINO, MD		22e. ADDRESS 4701 RANDOLPH RD - #416, ROCKVILLE, MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 20, 1987	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION CITY OR TOWN Lancaster COUNTY Worcester STATE Mass.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR OCT 22 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. These pages must be filed with the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

068928 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Russell Buckler Deisher</i>			2a DATE KNOWN OF DEATH MONTH DAY YEAR <i>Oct 10 1987</i>			2b DATE OF ESTI- MATED MATED MONTH DAY YEAR <i>Oct 10 1987</i>		
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>4/30/1918</i>	6 AGE (IN YEARS) LAST BIRTHDAY <i>69</i> YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Oct 10 1987</i>		7d HOUR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD		
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>720 Boundry Avenue</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>AAA</i>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>720 Boundry Ave. 20910</i>
14 FATHER'S NAME FIRST MIDDLE LAST <i>Howard Deisher</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mamie Buehler</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes</i>			16b SOCIAL SECURITY NO. <i>188-09-2187</i>		17 INFORMANT ADDRESS <i>Mrs. Margaret Tapscott As #13.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>								
19a DATE OF OPERATION <i>None</i>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. <i>Dep</i>			MEDICAL EXAMINER DATE SIGNED <i>Oct 11, 1987</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>			ADDRESS <i>1919 Seminary Rd. Sil. Spg, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b DATE <i>10/15/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Leesport Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Leesport Berks Co. Penna</i>		
24 FUNERAL DIRECTOR NAME <i>Takoma Funeral Home</i>		ADDRESS <i>254 Carroll St. Wash, D.C.</i>						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

97-B4
25MDHMH - 17
(VR A15 ME (5))

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text block]



[illegible text block]

069123 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas J. Delaney, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 10-11-87			2b. HOUR 1:10 A.M.				
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 18, 1892		6 AGE (IN YEARS (LAST BIRTHDAY)) 95		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SAFETY ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY AETNA		
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN CHEVY CHASE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6120 WESTERN AVENUE 20815	
14 FATHER'S NAME FIRST MIDDLE LAST THOMAS JAMES DELANEY			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH MARY DELANEY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWI		16b SOCIAL SECURITY NO. 577-03-7923		17 INFORMANT ADDRESS JOHN J. DELANEY/SON/SAME AS 13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:15 P.M. 10 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (LAST HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE						
22 I certify that (if (this hospital) attended the deceased from Jan 1987 to Oct 1987 that (we) last saw the deceased alive on Oct 10 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (we) (did not) view the body after death.										
22b SIGNATURE F. B. Smith		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 10-16-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. FRED SMITH				22e ADDRESS 5401 WESTERN AVENUE WASHINGTON, D.C.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 14, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD				
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a DATE RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE OCT 19 1987 Julia Davidson-Randall						
25b ADDRESS 500 UNIVERSITY BLVD SILVER SPRING, MD 20901										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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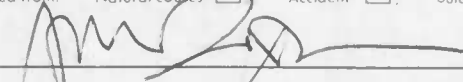
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST CORLISS A. DEMORY										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 25 1987		2b. HOUR 9:40 A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1934		6. AGE (IN YEARS) LAST BIRTHDAY 53 YRS.		IF UNDER 1 YR. MONTHS DAYS YES NO		IF UNDER 24 HRS. HOURS MIN. YES NO		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 27 1987		2d. HOUR 9:40 A M	
7a. BIRTHPLACE (STATE OR COUNTRY) Oklahoma				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 Lawrence Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Lawrence Dr. 20850					
14. FATHER'S NAME FIRST MIDDLE LAST Charles Rader				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Oliver				16. Gaithersburg, Md. 20879							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE NO. OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 441-32-9041				17. INFORMATION Corliss A. Sullivan(daughter)24316 Log House Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Isopropyl alcohol intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-25-1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject ingested rubbing alcohol.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 301 Lawrence Dr., Rockville, Montgomery, MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 10-28-87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D BY REGISTRAR NOV 02 1987				25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall							

DP-74
25M

BP

DHMH: 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

069627 OCT 26 87

1 - EOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT) Jacqueline M. Dengler		2b DATE OF DEATH MONTH DAY YEAR 10-18-87		2b HOUR 8:53 M	
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-21-98		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 89	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Care Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R.N.		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY PG		13c CITY OR TOWN HIGHLAND		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Fred Wendel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13e STREET ADDRESS / ZIP CODE 7005 GARDNER LA. / 20777			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT Jeanne Lindner-Highland		ADDRESS 7005 Gardner Lane, Md 20777	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER OF BREAST							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC ORGANIC BRAIN SYNDROME WITH SENILE DEMENTIA							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from MARCH 27 1981 to OCT 19 1987 , that (I) (we) lost saw the deceased alive on OCT 7 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Martin C. Shargel				DEGREE M.D.		22c DATE SIGNED 10/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL, M.D.				22e ADDRESS 3720 FARRAGUT AVE KENSINGTON MD - 20895			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCT/19/87		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, PG. CO. MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, Maryland				25a DATE REC'D. BY REGISTRAR OCT 23 1987		25b REGISTRAR'S SIGNATURE [Signature]	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and returned to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return a carbon copy of page 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, or medical condition, a medical examiner must be notified at once.

069133 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) KATHRYN EMILY DENNIS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 10 1987			2b HOUR 12:30 P M					
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JULY 8 1927		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA UNITED STATES		7b CITIZEN OF WHAT COUNTRY? MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD							
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROOF READER			12b KIND OF BUSINESS OR INDUSTRY PRINTING			
13a STATE MARYLAND		13b COUNTY PRINCE GEO'S		13c CITY OR TOWN SEABROOK		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6801 96th AVENUE 20706			
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE GROVER VEILY				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MARIE SPECHT							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS MICHAEL DENNIS, 6801 96th AVENUE, SEABROOK, MD 20706							
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTERVENTRICULAR HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 14 19 87, to OCTOBER 10 19 87, that (I) (we) last saw the deceased alive on OCTOBER 10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE T. R. Lovell						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 13 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) T. R. LOVELL, LCDR, MC, USN						22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE Oct. 15, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24 FUNERAL HOME NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25 DATE REC'D. BY REGISTRAR OCT 19 1987			25b REGISTRAR'S SIGNATURE Julia Denton-Rudolph		

BP

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DECEASED NAME FIRST MIDDLE LAST Martha J. Dickson			2b DATE OF DEATH MONTH DAY YEAR October 5, 1987		2c HOUR A 8:00 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR January 2, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTH DAY HOUR MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Collingswood Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Music Teacher	12b KIND OF BUSINESS OR INDUSTRY Education	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST J. W. Johnson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie L. Purvis		13e STREET ADDRESS / ZIP CODE 299 Hurley Avenue / 20850	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 066-28-3059		17 INFORMANT ADDRESS Leonard M. Trosten, 7505 Arrowood Road Bethesda, MD 20817	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Weak lungs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteriosclerosis Head Disease</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION (CITY OR TOWN COUNTY STATE)	
22a I certify that (I) (this hospital) attended the deceased from <u>June 9/6/87</u> 19 <u>87</u> to <u>10/5</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/5/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b SIGNATURE <u>Joel P. Segal</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/5/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joel P. SEGAL</u>		22e ADDRESS <u>5530 Wisc. Ave Chevy Chase Md</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 10-6-87	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION (CITY OR TOWN COUNTY STATE) Alexandria, Virginia	
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc.		ADDRESS P. O. Box 43352, Washington, DC 20010		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completely filled in by the funeral director), page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified for an autopsy.

BP

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FOR
DATE
REGISTRARper Med. Exam.
Film G632DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST Henry Joseph Dietle, Jr.			2a DATE KNOWN OF DEATH MONTH DAY YEAR 9/ 16/ 87		2b HOUR M 7:18 P M
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1952	6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 34 YRS	7c DATE PRONOUNCED DEAD MONTH DAY YEAR 9/ 16/ 87	7d HOUR M 7:18 P M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3650 Bel Pre Rd.		12a USUAL OCCUPATION (TYPE OF WORK OR NAME OF WORKING FIRM) Cook		12b KIND OF BUSINESS OR INDUSTRY Anchor Inn
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b CITY OR TOWN Maryland Montgomery Silver Spring			13c STREET ADDRESS 3650 Bel Pre Rd., 20906		
14 FATHER'S NAME FIRST MIDDLE LAST Henry J. Dietle, Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmen Vermillion		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. N/A 213-58-7868		17 INFORMANT ADDRESS 1454 Harrow Ave., Victoria Mackey-sister-Crofton, Md. 21114	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure Disorder</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 9/17/87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201			
23a BURIAL, CREMATION, REMOVAL Cremation		23b DATE 9-18-1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
				23d LOCATION (CITY OR TOWN) COUNTY STATE Alexandria Virginia	
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a DATE REC'D. BY REGISTRAR SEP 22 1987	
				25b REGISTRAR'S SIGNATURE <i>Julia Twiss-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, this medical certificate must be notified of office.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (LAST, FIRST, MIDDLE) John Patrick Dineen				2a. DATE OF DEATH MONTH DAY YEAR Oct 16 87				2b. HOUR A. M. 12:05	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 17 27		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Manhattan NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Grothersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1 Blue Ribbon Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. Health Assoc. of America	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Grothersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Blue Ribbon Court 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Dineen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Morrow							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korean		16b. SOCIAL SECURITY NO. 062-20-6430		17. INFORMANT WIFE		ADDRESS 1 Blue Ribbon Court Grothersburg			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Obstruction of Common Bile Duct									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 15 Aug 19 87 to 16 Oct 19 87 that (I) (we) last saw the deceased alive on 15 Oct 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Kevin M. Gil				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 16 Oct 87	
22d. PHYSICIAN'S NAME (TYPE IN PRINT) KEVIN M. GIL MD				22e. ADDRESS 15001 Duffel Mill Rd Grothersburg Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/87		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN STATE Woodside, New York			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE [Signature]			
1331 Rockville Pike, Rockville, Md. 20852									

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME (PRINT OR PRINT) Ettene Anathony DiSilvestri			2a DATE OF DEATH MONTH DAY YEAR 10/23/87		2b HOUR 1830 P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 4 2 14		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tile Setter	12b KIND OF BUSINESS OR INDUSTRY Self Employed	
13a STATE District of Columbia		13b COUNTY N/A	13c CITY OR TOWN Washington	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2613 Queens Chapel Road N.E. 20018
14 FATHER'S NAME FIRST MIDDLE LAST Antonio DiSilvestri		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Bucco		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 579-07-8836		17 INFORMANT Lockretta DiSilvestri		Same as #13 above	

11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

SPECIAL NOTE: SIGNATURE OF PHYSICIAN

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on above (I) (we) did not view the body after death.			
22b SIGNATURE Lewis H. Dennis		DEGREE M.D.	22c DATE SIGNED 10/23/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis		22e ADDRESS 831 UNIV. BLVD E. Silver Spring, Md	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/27/87	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince George's, Md.
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		25a DATE REC'D. BY REGISTRAR NOV 04 1987	25b REGISTRAR'S SIGNATURE Julia T. ...

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible signature]

[illegible text]

[illegible text]

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. A medical examiner must be notified of death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG NO			
1- FOR STATE REGISTRAR				7 2 9 7 1 4			
1 DECEASED NAME FIRST MIDDLE LAST Eugenia Mikuliak DOUDNIKOFF Doudnikoff				2a DATE OF DEATH MONTH DAY YEAR 10 22 87 1040M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 22, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a BIRTHPLACE (COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Mt. Airy		13e STREET ADDRESS / ZIP CODE 1270 Ridge Rd. 21771	
14 FATHER'S NAME FIRST MIDDLE LAST Ilyarun Mikuliak				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cristine unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 155-22-2573		17 INFORMANT Bill Doudnikoff,		ADDRESS Item 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							(b) <u>Cerebrovascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF							(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>87</u> to <u>10/22</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE B. S. Talerick				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/22/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARRY S. TALERICK MD				22e ADDRESS 8711 Mount Green Park Rockville MD 20850			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 24, 1987		23c NAME OF CEMETERY OR CREMATORY Pine Grove		23d LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md.	
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.,				ADDRESS Damascus, Md.		25a DATE REC'D BY REGISTRAR OCT 28 1987	
				25b REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

RICHARD

E.

DRONEBERGER

2a DATE OF DEATH

MONTH DAY YEAR
10 1 87

2b HOUR

5P.M.

3 SEX

MALE

4 RACE

CAUCASIAN

5 DATE OF BIRTH

MONTH DAY YEAR
APRIL 18 1931

6 AGE (IN YEARS LAST BIRTHDAY)

56

7a BIRTHPLACE
(COUNTRY)

KANSAS

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10 CITY OR TOWN OF DEATH

TAKOMA PARK

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

WASHINGTON ADVENTIST HOSPITAL

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

ELEVATOR INS.

12b KIND OF BUSINESS OR
INDUSTRY

MARYLAND STATE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

PR GEORGES

13c. CITY OR TOWN

RIVERDALE

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

5510 TAYLOR ROAD 20737

14. FATHER'S NAME

FIRST
WILLIAM

MIDDLE

O.

LAST

DRONEBERGER

15 MOTHER'S MAIDEN NAME

FIRST
MARILYN

MIDDLE

F.

LAST

CAMPBELL

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

YES

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

025-24-0831

17 INFORMANT

HAZEL HAYES/FRIEND/SAME AS 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

respiratory failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1h

DUE TO, OR AS A CONSEQUENCE OF

(b)

cancer of lung

1h

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)21f LOCATION
STREET

(CITY OR TOWN)

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 10/1/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF
PHYSICIAN DIRECTOR PHYSICIAN

22c DATE SIGNED

10/2/87

22d PHYSICIAN'S NAME (PRINT OR TYPE)

22e ADDRESS

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

CREMATION

23b DATE

OCT6, 1987

23c NAME OF CEMETERY OR CREMATORY

METROPOLITAN CREMATORY ALEXANDRIA

23d LOCATION
(CITY OR TOWN)

COUNTY

STATE

VIRGINIA

24 FUNERAL DIRECTOR
NAME

FRANCIS J. COLLINS, JR.

25a DATE REC'D. BY REGISTRAR

OCT 07 1987

500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

067898 OCT-061

Therapy

Therapy

10-1-81

Therapy

Therapy

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OCT 01 1981

068696 OCT 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN E. DULEY			2a DATE OF DEATH MONTH DAY YEAR 10 11 87		2b HOUR 4 30 A.M.
3 SEX MALE	4 RACE CAUC.	5 DATE OF BIRTH MONTH DAY YEAR 11 21 39	6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS	7 IF UNDER 1 YEAR MONTH DAY HOURS MIN 8 IF UNDER 72 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher	12b KIND OF BUSINESS OR INDUSTRY County Gov't	
13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Rockville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST John Burton Duley			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Whalen		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 36 2550	17 INFORMANT ADDRESS Nancy S. Duley wife, see #13			
18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HOURS
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) ACUTE MYOCARDIAL INFARCTION					0
DUE TO, OR AS A CONSEQUENCE OF c) CORONARY ARTERY DISEASE					4 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from 10/7 19 87 to 10/11 19 87 that (I) (we) last saw the deceased alive on 10/11 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22a SIGNATURE D. R. Rosing M.D.		DEGREE MD.		22c DATE SIGNED 10/11/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS R. ROSING M.D.		22e ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MD 20852			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 1987 Oct. 12	23c NAME OF CEMETERY OR CREMATORY Montgomery Crematorium		23d LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Av., Rockville, Md.			25 DATE REC'D BY REGISTRAR OCT 14 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the funeral director. Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the funeral director.

IMPORTANT: If item 21 is marked as item 18, there is only injury, or other traumatic event, the medical examiner must be notified at once.

067766 OCT-78

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) CLIFFORD BENJAMIN DYER			2a. DATE OF DEATH MONTH DAY YEAR October 31 1987			2b. HOUR 7:05 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 28 1901		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 SLIGO AVENUE				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN - MUSICIAN		12b KIND OF BUSINESS OR INDUSTRY SAME	
13a STATE MD.		13b COUNTY MONT.		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 700 SLIGO AVE. 20910	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES CLIFFORD DYER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARION ELLA SABASTIAN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17 INFORMANT WILLIS F. MATTHEWS		ADDRESS 700 SLIGO AVE SS MD			
18 CAUSE OF DEATH Enter only one cause per line for 18a, 18b and 18c PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 2 weeks ?									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 2 Oct 87 to 3 Oct 87 that (I) saw the deceased alive on 2 Oct 87 and that in my own opinion death occurred on the date and hour and from the causes stated above. (I was did not view the body after death.)									
22b SIGNATURE William D. Aud M.D.						DEGREE M.D.		22c DATE SIGNED 10/3/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. AUD. M.D.						22e ADDRESS 9006 Colverly Rd. Silver Spring MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE OCT. 7, 1987		23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Washington DC		
24 FUNERAL DIRECTOR NAME ADDRESS Takoma Funeral Home 254 Carroll St. N.W. DC									
25a DATE REC'D. BY REGISTRAR OCT 06 1987						25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

DATE: 10/24/70
PAGE: 1

TO: Mr. J. Edgar Hoover
FROM: Mr. [Name]

SUBJECT: [Subject]

RE: [Subject]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

38079 OCT-88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Kathleen M. Edwards			2a DATE OF DEATH MONTH DAY YEAR 10/4/87		2b HOUR 4:15 A M	
3 SEX Female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Jan. 19 1911		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a USUAL OCCUPATION Health & Welfare Counsel		12b KIND OF BUSINESS OR INDUSTRY Private	
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 8201 16th Street 20910		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Murray		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maladie (unknown)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		16b SOCIAL SECURITY NO (IF YES, GIVE LAST FOUR DIGITS) N/A		17 INFORMANT ADDRESS Harry Edwards-son-(same as 13e)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS AN IMMEDIATE CONSEQUENCE OF Abdominal Catastrophe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)						
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Aspiration Pneumonia						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (his hospital) attended the deceased from 10/13/87 to 10/4/87 that I, we, last saw the deceased alive on 10/13/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) we (I) did not view the body after death						
22b SIGNATURE ALAN I. KERMAIER		DEGREE M.D.		22c DATE SIGNED 10/4/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER		22e ADDRESS 11800 N.H. Ave., Hines/Rinaldi Funeral Home Silver Spring, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-6-1987		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		
24 FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a DATE REC'D. BY REGISTRAR OCT 06 1987		
25b REGISTRAR'S SIGNATURE ~ [Signature]						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

11



RECEIVED
OCT 10 1967
FBI - NEW YORK

68352 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Grace Campbell Egolf			2a DATE OF DEATH MONTH DAY YEAR 10 2 1987		2b HOUR A. M. 7:30	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE MD		13b COUNTY Mont.	13c CITY OR TOWN Chevy Chase	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 5100 Dorset Ave. 20815	
14 FATHER'S NAME FIRST MIDDLE LAST John A. Campbell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Rake				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 217-28-7830		17 INFORMANT ADDRESS Rockville, MD 20852 Harry Clarkson 11315 Commonwealth Dr.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 10 YRS						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD & CHF						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) this hospital attended the deceased from 9/4/87 19 to 10/2/87 19 that (2) I saw the deceased alive on 9/4/87 and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (3) I did not view the body after death						
22b SIGNATURE Henry C. Scruggs				DEGREE MD		22c DATE SIGNED 10/2/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs, M.D.				22e ADDRESS 5413 W. Cedar Lane, Bethesda, Md 20814		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial- Removal		23b DATE 10/7/87		23c NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Tulsa Tulsa Ok
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a DATE REC'D BY REGISTRAR OCT 09 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The following is a true and correct copy of the death certificate as filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Chadwick & M.E.

069895 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)		FIRST GREGORY		MIDDLE LEE		LAST ELLIS		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-17-87		7b HOUR M	
3 SEX M	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR Dec 13 1968		6 AGE (IN YEARS) (LAST BIRTHDAY) 18 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10-17-87		7d HOUR 6:53 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mover		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md		13b COUNTY Montgomery		13c CITY OR TOWN Germantown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 18601 Sageway 20874			
14 FATHER'S NAME FIRST MIDDLE LAST Ralph Thomas Ellis				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Alice Bright				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 215 80 4926				17 INFORMANT Ralph T. Ellis				ADDRESS Germantown 19240 Warrior Drive			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds (2) to torso</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I - a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR MONTH DAY YEAR 5:35 PM 10-17-87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) street		21f LOCATION CITY OR TOWN STREET COUNTY STATE 18620 Glen Willow Way Germantown, Maryland							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER				DATE SIGNED 10-18-87			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Margarita A. Korell, M.D. 111 Penn Street									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct 23 1987		23c NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens				23d LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md			
24 FUNERAL DIRECTOR NAME C.E. Hicks		ADDRESS 111 1922 Forest Drive Anna.Md		25a DATE REC'D BY REGISTRAR OCT 26 1987		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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DHMH - 17
(VR A15 ME (15))

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069129 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ALFIN EPPLEY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1987		2b HOUR 9:30 PM
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 3, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 91	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH POTOMAC	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11400 ROUEN DRIVE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKBINDER	12b KIND OF BUSINESS OR INDUSTRY NATL CAPITOL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN POTOMAC 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS / ZIP CODE 11400 ROUEN DRIVE 20854 PRESS					
14 FATHER'S NAME FIRST MIDDLE LAST JOHN A. EPPLEY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN L. SMART			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1917-1919	17 INFORMANT ADDRESS MARY ELLEN BRAIN/DAUGHTER/SAME AS 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Lymphoma</u> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>March 5th</u> 19 <u>87</u> to <u>September 28</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>September 28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Jeffrey M. Crane</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 10/13/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jeffrey M. Crane</u>		22e ADDRESS 14801 Physicians Lane Suite 271 Rockville, MD 20850			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT15, 1987	23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRINCE GEORGES MD
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE RECD. BY REGISTRAR OCT 19 1987 25b REGISTRAR'S SIGNATURE <u>John D. Anderson</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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067733 OCT-78

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29922

1. DECEASED NAME (TYPE OR PRINT) FIRST: <i>MORRIS</i> MIDDLE: <i>M.</i> LAST: <i>Epstein</i>			20. DATE OF DEATH MONTH: <i>10</i> DAY: <i>2</i> YEAR: <i>87</i>		2b. HOUR <i>1:45 PM</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH: <i>9</i> DAY: <i>21</i> YEAR: <i>99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6111 Montrose Rd.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SALES</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>

13a. STATE <i>Md.</i>			13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE <i>6111 Montrose Rd. 20852</i>	
14. FATHER'S NAME FIRST: <i>Ellis</i> MIDDLE: <i>Epstein</i> LAST: <i>Epstein</i>			15. MOTHER'S MAIDEN NAME FIRST: <i>Unknown</i> MIDDLE: <i>Unknown</i> LAST: <i>Unknown</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>		
16b. SOCIAL SECURITY NO. <i>153-10-0887</i>			17. INFORMANT <i>Madeline Epstein Fishman</i>			ADDRESS <i>4701 Willard Ave Cherry Chase, Md. 20815</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic Obstructive Lung Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET: <i></i> CITY OR TOWN: <i></i> COUNTY: <i></i> STATE: <i></i>	
22a. I certify that (I) this hospital attended the deceased from <i>MAY 1979</i> to <i>OCT 1987</i> that (I) XX lost saw the deceased alive on <i>10/1/87</i> 19 <i></i> and that in (my) XXX opinion death occurred on the date and hour and from the causes stated above (I) we (did) (did not) view the body after death.			

22b. SIGNATURE <i>David M. Epstein</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>10/2/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David M. Epstein</i>		22e. ADDRESS <i>4701 Willard Ave #533 Cherry Chase Md. 20852</i>	

23a. BURIAL, CREMATION, REMOVAL (SEE #1) <i>Burial</i>	23b. DATE <i>Oct. 6, 1987</i>	23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Park</i>	23d. LOCATION CITY OR TOWN: <i>Falls Church, Va.</i> COUNTY: <i></i> STATE: <i></i>
24. FUNERAL DIRECTOR NAME <i>Ives Pearson Funeral Homes</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 06 1987</i>	
		25b. REGISTRAR'S SIGNATURE <i>J. L. Pearson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.)

067733 OCT-781

OCT 08 1981

069173 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 2 9 9 2 3

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Marie</u> MIDDLE <u>H.</u> LAST <u>Errol-Johnson</u> <u>MARIE H. ERROL-JOHNSON</u>		2a. DATE OF DEATH MONTH <u>9</u> DAY <u>30</u> YEAR <u>1987</u>		2b. HOUR <u>1040</u> ^A	
3 SEX <u>FEMALE</u>	4 RACE <u>CAUCASIAN</u>	5. DATE OF BIRTH MONTH <u>2</u> DAY <u>28</u> YEAR <u>1898</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>89</u> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NE</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 <u>BALTIMORE CITY OR COUNTY OF DEATH</u> <u>Montgomery</u> MD	
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Exec. Sect.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Leg. Consultant</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <u>---</u> 13b COUNTY <u>---</u> 13c CITY OR TOWN <u>Washington, DC</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>4000 Cathedral Ave., NW/20016</u>	
14 FATHER'S NAME FIRST <u>Pontus</u> MIDDLE <u>---</u> LAST <u>Bergstrom</u>		15 MOTHER'S MAIDEN NAME FIRST <u>Anna</u> MIDDLE <u>---</u> LAST <u>Anders</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES) <u>---</u>		16b SOCIAL SECURITY NO. <u>577-24-9544</u>		17 INFORMANT <u>2400 Sanford St.</u> <u>Emily M. Glaub, Alexandria, VA</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Renal Vase</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>22 Nov 1987</u> to <u>30 Dec 1987</u> that (I) (we) last saw the deceased alive on <u>29 Dec 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>30 Dec 87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Leibach, MD</u>		22e ADDRESS <u>1120 Maine St NW 20404</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>10/2/87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d LOCATION CITY OR TOWN <u>Suitland, MD</u>		23e COUNTY <u>---</u> STATE <u>---</u>			
24 FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>		24b ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C. 20016</u>		25a DATE REC'D BY REGISTRAR <u>OCT 16 1987</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c REGISTRAR'S NAME <u>Julia D. [Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, and the examiner must be notified of any injury.

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OCT 18 1901

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

070138 OCT 1987

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST Jose	MIDDLE ---	LAST Otero Espasandin	2a DATE OF DEATH	MONTH 10	DAY 15	YEAR 87	2b HOUR	9:30 PM	
3 SEX		4 RACE		5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		7. UNDER 24 HRS		
male		White		MONTH 12 DAY 08 YEAR 00	86 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Spain		U.S.A.				Montgomery County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hosp				Civil Servant-Pan Am.		HealthOrg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			
MD		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Rafael		Soledad		No		196-26-9595A		Giuliano Comba, 346 E. 51st St., New York, NY			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE										24 HRS	
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION										4 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE IN DEF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY			21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR									
21d INJURY OCCURRED		21e PLACE OF INJURY			21f LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		(AT HOME STREET FACTORY OFFICE FARM ETC.)			STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from 9-25-1987 to 10-14-1987, that (I) (we) lost saw the deceased alive on 10/14/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE										22c DATE SIGNED	
Francis C. Mayle										10/16/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS	
Francis C. Mayle										2081 W. Wisconsin Ave Bethesda MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY STATE			
Cremation		10/20/87		Mt. Comfort Crematory		Alexandria, VA					
24 FUNERAL DIRECTOR						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016						OCT 28 1987		Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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WASHINGTON, D.C.

10/19/61

070641 NOV-387

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anita M FAINA			2a DATE OF DEATH MONTH DAY YEAR 10 27 87		2b HOUR 2:30 P.M.	
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 3 27 14		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 73		
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE MARYLAND		13b COUNTY PR GEORGES		13c CITY OR TOWN HYATTSVILLE		
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH RONCAGLIOLO		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERESA TESSARA		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-03-7656		17 INFORMANT ADDRESS GEORGE J. FAINA/HUSBAND/SAME AS 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 9/30 19 87 to 10/27 19 87 that (I) (we) last saw the deceased alive on 10/27 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE S. Laby-Gottstein				22c DATE SIGNED 10/27/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Shelley LABY-GOTTSTEIN				22e ADDRESS 1106 Spring St. Silver Spring, Md.		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT30,1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <i>John D. ...</i>		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed - then 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (PRINT) VERONICA A. FAVREAU		2a DATE OF DEATH MONTH DAY YEAR 10/24/87		2b HOUR 9:45 AM	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 2-8-25		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland	13b COUNTY Pr. Geo.	13c CITY OR TOWN Adelphi	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2616 Hughes Road 20783	
14 FATHER'S NAME FIRST MIDDLE LAST Charles McCormick		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 208-16-6446		17 INFORMANT Robert F. Favreau Husband Same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bone marrow necrosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastatic small cell carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) lung cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks 3 mo 3 mo
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a none					
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS INVOLVED <input type="checkbox"/> OR CONTRIBUTED <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) —	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR WHILE NOT AT WORK <input checked="" type="checkbox"/> N/A		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from 19 10/24 to 19 87 that (1) I saw the deceased alive on 10/24 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (I) did (I did not) view the body after death.					
22b SIGNATURE Kathryn S. Kirwin MD				22c DATE SIGNED 10/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KATHRYN S. KIRWIN MD				22e ADDRESS 10400 Conn. Ave Suite 606, Kensington, Md.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 28, 1987		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		23e DATE REC'D BY REGISTRAR 23f REGISTRAR'S SIGNATURE OCT 29 1987			
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. 20901					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

070742 NOV 4 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN E FREISSNER JR.			2a DATE OF DEATH MONTH DAY YEAR 10 31 1987			2b HOUR P 0700				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 03 30 1896		6 AGE (IN YEARS LAST BIRTHDAY) YRS 91		IF UNDER 1 YEAR IF UNDER 20 YRS IF UNDER 20 YRS IF UNDER 20 YRS		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Penn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (IF WORKING FOR MORE THAN ONE WORKING LIFE, INDUSTRY) Retired Auditor		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland		13b COUNTY Montg.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 620 Silver Spring Ave.		13e ZIP CODE 20910		
14 FATHER'S NAME FIRST MIDDLE LAST Herman Feissner		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Seortz		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR BOTH; GIVE BRANCH, SERVICE, AND DATES) yes U.S. Army						
16b SOCIAL SECURITY NO. 577-20-1907		17 INFORMANT NAME ADDRESS Karl H. Feissner (13e)								
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aspiration pneumonia with DUE TO, OR AS A CONSEQUENCE OF septic shock Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/31 1987			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from 10/31 1987 to 10/31 1987 , that (2) (two) lost saw the deceased live on 10/31 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (I) did not view the body after death										
22b SIGNATURE B. H. ROSENBAUM			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/31/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. H. ROSENBAUM			22e ADDRESS 3720 FARRAGUT AVE KEESING TOWN, MD 20895							
23a BURIAL, CREMATION, REMOVAL (TYPE BY) Burial.			23b DATE Nov. 4-1987			23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d LOCATION (CITY OR TOWN) COUNTY STATE Brentwood. P. G. Co. Md.	
24a JUDICIAL OFFICE Takoma Funeral Home Inc			24b JUDICIAL OFFICE 54 Carroll St. N. W. D. C.			25a DATE REC'D BY REGISTRAR 11-5-87		25b REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by R. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this certificate in page 4 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

069061 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) SADIE FISHMAN			2a DATE OF DEATH MONTH DAY YEAR 10-13-87			2b HOUR 9:30 PM		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB. 25, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b KIND OF BUSINESS OR INDUSTRY AT HOME	
13a STATE D.C.		13b COUNTY NONE		13c CITY OR TOWN WASHINGTON		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST JACOB ALPERN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA RENNERT		13e STREET ADDRESS 4530 CONN. AVE. 20008				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 090-03-9952		17 INFORMANT RHODA SCHOEN				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) bladder tumor DUE TO, OR AS A CONSEQUENCE OF (c) depression APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) (this hospital) attended the deceased from 11-5-1985 to 10-13-1987 that (I) (we) last saw the deceased alive on 10-13-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE S. SUDHAKAR				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10-14-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. SUDHAKAR				22e ADDRESS HEBREW HOME, ROCKVILLE, MD.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-14-1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.		
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS 20910 SILVER SPRING, Md.		25a DATE REC'D. BY REGISTRAR OCT 19 1987		
				25b REGISTRAR'S SIGNATURE Julia Davis				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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069469 OCT 23 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

DECEASED NAME (FIRST OR PRINT)		FIRST Bernard		MIDDLE M.		LAST Fitzgerald		2a. DATE KNOWN OF DEATH ESTIMATED MONTH 10/14 DAY 19 YEAR 87		2b. HOUR 11:20 AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH May DAY 21 YEAR 1899		6 AGE (IN YEARS) LAST BIRTHDAY 88 YRS.	IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH 10/14 DAY 19 YEAR 87 A.M.		2d. HOUR 11:20 AM
7a. BIRTHPLACE (COUNTRY OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15101 Interlaken Drive UNIT#901				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER AM. COKE-COAL CHEMICALS			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS UNIT #901 20906 15101 Interlaken Drive			
14 FATHER'S NAME FIRST MICHAEL MIDDLE FITZGERALD LAST FITZGERALD		15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE WALSH LAST WALSH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 349-07-6701		17 INFORMANT ADDRESS CLARA F. FITZGERALD/WIFE/SAME AS 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 10/14/87			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT16,1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM LPM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH-17
(VR A15 ME (5))

160489 OCT 23 W

Howard

M.

Elizabeth

10114 89

Male

White May 21, 1899 88

10114 89

Montgomery County

Silver Spring 1910 Interlocken Drive

Montgomery Silver Spring 1910 Interlocken Drive

acute myocardial disease.

None

None

None

X

X

Levity

1919 Cemetery Road

Silver Spring, Montgomery County, MD

John B. Rogers, M.D.

OCT 23 W

070433 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 29930	
1 DECEASED NAME (TYPE OR PRINT) CORNELIA ELIZABETH FLAHERTY						2a DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 10 27 1987		7b HOUR A			
3 SEX F		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR 05 21 02		6 AGE (IN YEARS) (LAST BIRTHDAY) 85 YRS		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 27 1987		7d HOUR 0815	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b CITIZEN OF WHAT COUNTRY? United States				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10 CITY OR TOWN OF DEATH BETHESDA				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7809 WINTERBERRY PL.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Branch Manager		12b KIND OF BUSINESS Western Union	
13a STATE MD						13b COUNTY MONTGOMERY		13c CITY OR TOWN BETHESDA		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e STREET ADDRESS 7809 WINTERBERRY PL.						13f STREET ADDRESS 20817					
14 FATHER'S NAME FIRST MIDDLE LAST not available Martin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Powers							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b SOCIAL SECURITY NO. 577-07-0561				17 INFORMANT ADDRESS Roger Flaherty, same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDENT											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 DIABETES MELLITUS											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR AM. 10 27 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Found on Floor					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f LOCATION STREET CITY OR TOWN COUNTY STATE 7809 WINTERBERRY PL. BETHESDA MONT. MD					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayke						TITLE (SPECIFY) DEPT		MEDICAL EXAMINER		DATE SIGNED 10/27/87	
EXAMINER'S NAME (TYPE OR PRINT) FRANCIS C MAYKE						ADDRESS 8200 Wisconsin Ave Bethesda MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE Oct. 29, 1987		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814						25a DATE REC'D BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Rudner			

07-84
25M

BP

DHMH - 17
(VR A15 ME (1))

010488-10450



UNITED STATES OF AMERICA

RECEIVED OCTOBER 20 1965

OCT 20 1965

68633 OCT 15 1987

Item 6 Film G632 10-14-87 SB STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 9 3 1

1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST RUTH FLAHERTY				MONTH DAY YEAR Oct. 5 1987				12 50 A			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MONTH DAY YEAR JUNE 7 1918		9 YRS		MONTHS		HOURS MIN	
10 CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY				12b KIND OF BUSINESS OR INDUSTRY HUMAN SERVICES							
13a STATE MARYLAND				13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8418 QUEEN ANNES DRIVE 20910	
14 FATHER'S NAME FIRST MIDDLE LAST NELSON V. FLAHERTY				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AVIS DEISHER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO 578-16-9453		17 INFORMANT ADDRESS JANIE F. HAYZLETT/SISTER/SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System Lymphoma 8 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from June 1987 to 10/5 1987 that I last saw the deceased alive on 9/30 1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death											
23 SIGNATURE G. LEONARD GOLD								DEGREE M.D.		22c DATE SIGNED 10/5/87	
23a PHYSICIAN'S NAME (TYPE OR PRINT)								22e ADDRESS 8630 FENTON STREET SILVER SPRING, MD 20910			
23b BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE OCT9, 1987		23c NAME OF CEMETERY OR CREMATORY MT. ELBERT CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE EAGLE ROCK BOTETOURT VIRGINIA			
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901								25a DATE REC'D. BY REGISTRAR OCT 13 1987			
								25b REGISTRAR'S SIGNATURE John Davidson-Rodell			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the certificate in the container for the deceased, and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Central Western System (Lapland) 8-10-12

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OCT 13 1912

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SADYE R. FLINT			2a. DATE OF DEATH MONTH DAY YEAR 10-10-87			2b. HOUR 1830 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 14 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper	
12b. KIND OF BUSINESS OR INDUSTRY Small Business		13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6111 Montrose Road #206		14. FATHER'S NAME FIRST MIDDLE LAST Jacob Zimmerman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sharfstein	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS 1649 E. Jefferson #202		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHRONIC RENAL FAILURE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22a. DATE SIGNED 10/10/87	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6246 Montrose Rd Rockville MD		22b. SIGNATURE Stephen Hellman	
22c. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/10/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Hellman		22e. ADDRESS 6246 Montrose Rd Rockville MD		22f. DATE SIGNED 10/10/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE October 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Eretz Hachaim		23d. LOCATION CITY OR TOWN COUNTY STATE Israel	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Falls Church, VA		25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE Julie Jordan		25c. REGISTRAR'S SIGNATURE	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

060777 OCT 1901

Caucasian

U.S.A.

New York

OCT 15 1901

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

29933

1 DECEASED NAME (TYPE OR PRINT) STEPHANIE SAYAKA FLOOD			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 23 1987		2b HOUR 9:08 A _M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR OCTOBER 3 1987		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 20	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY N/A
13a STATE MARYLAND			13b COUNTY ANNE ARUNDEL	13c CITY OR TOWN FT. MEADE	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN JOSEPH FLOOD			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST YUKIKO YONAMINE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO N/A		17 INFORMANT ADDRESS JOHN J. FLOOD, 8011-D LESLIE ROAD, FT. MEADE, MD 20755	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGENITAL BRAIN MALFORMATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) did not attended the deceased from <u>OCTOBER 3</u> , 19 <u>87</u> , to <u>OCTOBER 23</u> , 19 <u>87</u> , that (I) was last saw the deceased alive on <u>OCTOBER 23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) did not (did) view the body after death.					
22b SIGNATURE <i>L.M. Clapper</i> DEGREE <i>MD</i>				22c DATE SIGNED <i>10/26/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) L.M. CLAPPER, LT, MC, USN				22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE Oct. 28, 1987		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
				23d LOCATION CITY OR TOWN COUNTY STATE Janesville, Wisconsin	
24 FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va. 22201				25a DATE REC'D. BY REGISTRAR OCT 27 1987	
				25b REGISTRAR'S SIGNATURE <i>L. B. ...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (1) it shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. F. Mayle Medical Examiner's office 10/22/87

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
DECEASED NAME FIRST MIDDLE LAST RALPH E. FRANKLIN				10 - 21 - 87			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 17, 1919		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 68	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY Carpenter	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13e STREET ADDRESS / ZIP CODE 707 Edmonston Drive 20851	
14 FATHER'S NAME FIRST MIDDLE LAST John D. Franklin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Vaughn			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II 407-07-7029		17 INFORMANT ADDRESS Vermont Franklin (wife) same as 13e			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMOCOCCAL SEPTICEMIA. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC OBSTRUCTIVE LUNG DISEASE; CHRONIC LIVER DISEASE							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) the hospital attended the deceased from 10/20 19 87 to 10/21 19 87 that (2) I last saw the deceased alive on 10/21 19 87 , and that in my (1) own opinion death occurred on the date and hour and from the causes stated above, (2) (check one) I saw the body after death							
22b SIGNATURE Carl I. Schenberger				DEGREE MD		22c DATE SIGNED 10/21/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CARL I. SCHENBERGER				22e ADDRESS 4701 RANDOLPH RD ROCKVILLE			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/23/87		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a DATE RECD. BY REGISTRAR OCT 23 1987		25b REGISTRAR'S SIGNATURE Julia Trishon-Rublee	
1331 Rockville Pike, Rockville, Md. 20852							

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHLYNE S FREEMAN				2a. DATE OF DEATH MONTH DAY YEAR 10 6 87				2b. HOUR 3 A.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 23 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7401 25th Avenue 20783	
14. FATHER'S NAME FIRST MIDDLE LAST Edward S. Smalls				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST America H. Smalls					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 34 1394		17. INFORMANT ADDRESS Karrissa Freeman-daughter-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ANASARCA, PLEURAS EFFUSION DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITES, TUBULAR ACIDOSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-18-1987 to 10-6-1987 that (I) (we) last saw the deceased alive on 10/5/1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Tom P. Karmarkut				DEGREE MD				22c. DATE SIGNED 10/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KANVAR/KAT. MD				22e. ADDRESS 8201 16th St, S.S. MD 20910					
23a. BURIAL, CREMATION, REMOVAL (CHECK BY)			23b. DATE Oct. 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.		
24. FUNERAL DIRECTOR NAME Stewart Funeral Home				4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

29930

1. DECEASED NAME (TYPE OR PRINT) MARVIN FRIEDKIN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-25-87		2b. HOUR 1:50 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 11 1919	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk - Federal Government	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 12718 Robindale Dr.
14. FATHER'S NAME FIRST MIDDLE LAST Harry Friedkin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 130-07-1505		17. INFORMANT Helen Friedkin	
16c. ADDRESS same address as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Richard L. Whelton		TITLE (SPECIFY) Medical Examiner		DATE SIGNED 10-25-87	
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON		ADDRESS 4700 Benoyan House Rd College Falls			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Oct. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY King David Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia
24. FUNERAL DIRECTOR'S NAME Dr. Pearson Funeral Homes Falls Church, Va. 22046			25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE John Dodson-Rudell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MYRTLE B. FULTON			2a. DATE OF DEATH MONTH 10 / DAY 28 / YEAR 1987		2b. HOUR 2:10 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Sept. / DAY 20 / YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91	7. UNDER 1 YEAR MONTH YRS / DAY / HOUR / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY AVENUE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Cook
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	
14. FATHER'S NAME FIRST William MIDDLE Herbert LAST Blodgett			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Abbie LAST Gray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 003-18-2552		17. INFORMANT ADDRESS Arnold G. Oakes (son) same as 13e	
18. CAUSE OF DEATH - Enter only one cause per line for each condition PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes, Osteoarthritis, Heart Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from January 1980 to October 1987 that (I) (we) last saw the deceased alive on Oct 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE Blaine Eig				DEGREE M.D.	22c. DATE SIGNED OCT. 28, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE EIG, M.D.				22e. ADDRESS 9801 GEORGIA AVE. #340, SILVER SPR., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/28/87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852				25. DATE RECEIVED BY REGISTRAR NOV 02 1987 25b. REGISTRAR'S SIGNATURE Julia B. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Robert P. FUSS		7a DATE KNOWN OF DEATH ESTIMATED Oct 31 1987	
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR July 24 1961	6 AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS 26 1 1
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b CITIZEN OF WHAT COUNTRY? USA	
10 CITY OR TOWN OF DEATH Spr. Md.		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C&P TELEPHONE COMPANY		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY Montgomery	
13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS 12510 PLAZA PLACE 20853		14 FATHER'S NAME FIRST MIDDLE LAST OTTO P. FUSS	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY I. STEEP		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES	
16b SOCIAL SECURITY NO. 1945-1947		17 INFORMANT WINIFRED A. FUSS/WIFE/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 chr. Obstructive Pul Dis			
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D.	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS		ADDRESS SEMINARY ROAD SILVER SPRING, MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE NOV 3, 1987	
23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D. BY REGISTRAR NOV 06 1987	
25b REGISTRAR'S SIGNATURE Francis J. Collins, Jr.			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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John P. Jones

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REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) Martin		FIRST MIDDLE LAST GANOCZY		2a. DATE OF DEATH October 05, 1987		MONTH DAY YEAR 9:50 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOTIFY SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nuclear Technic		12b. KIND OF BUSINESS OR INDUSTRY US Gov't	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Martin Ganoczy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Hart		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1955		17. INFORMANT Marta Ganoczy, Wife, Same as No. 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Minutes		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 FOR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) _____ attended the deceased from 9:30pm 10/05 19 87 to 9:50 pm 10/05 87 that (b) _____ last saw the deceased alive on Oct. 5, 19 87 and that in my (b) _____ opinion death occurred on the date and hour and from the causes stated above (b) (c) did view the body after death.							
22b. SIGNATURE Alexander Fleming MD				DEGREE MD		22c. DATE SIGNED Oct. 5, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander Fleming, M.D.				22e. ADDRESS Emer. Dept., Washington Adventist Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-07-87		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, PG Co., Maryland	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CORP., Silver Spring, MD 20910				25. DATE REC'D. BY REGISTRAR (25a. REGISTRAR'S SIGNATURE) OCT 15 1987			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR				2b HOUR	
James E. Gardner						October 29 1987				2205 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS, LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 28, 1929		58		YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				MONTGOMERY MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville		SHADY GROVE ADVENTIST HOSPITAL						Retired Carpenter		Sub-Contractor	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE		
Maryland			Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20877 17060 King James Way #606		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Elbert R. Gardner			Lottie M. Randall			Yes Korea 218-24-6644					
16b SOCIAL SECURITY NO			17 INFORMANT			Silver Spring, Md. 20906					
Shirley M. Bruce (sister)			12324 Middle Rd.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Esophageal Carcinoma</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
			P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION (CITY OR TOWN, COUNTY, STATE)					
22 I certify that (1) the hospital attended the deceased from <u>August 1</u> , 19 <u>87</u> to <u>October 29</u> , 19 <u>87</u> that (2) I saw the deceased alive on <u>29 October</u> , 19 <u>87</u> , and that in my (four) opinion death occurred on the date and hour and from the causes stated above; (3) I was not and did not see the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED		
Jeffrey M. Crane			M.D.						10/30/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS								
JEFFREY M. CRANE M.D.			Shady Grove Medical Village Suite 271 14801 Physicians Lane Rockville, MD 20850								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (CITY OR TOWN, COUNTY, STATE)			
Burial			11/2/87		Parklawn Memorial Park			Rockville, Maryland			
24 FUNERAL DIRECTOR (NAME)						25a DATE REC'D. BY REGISTRAR (1) REGISTRAR'S SIGNATURE					
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						NOV 06 1987 Julie Gordon-Randall					

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10-10-68 44-38861-101

SECRET

NOV 68

1731 Rockville Pike, Rockville, Md. 20852
Tyson Wheeler, General House, Inc.

070416 NOV-21 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at birth.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
FOR STATE REGISTRATION					REG. NO.										
1 DECEASED NAME (TYPE OR PRINT) Dorothy G. Garrahan					2a DATE OF DEATH MONTH DAY YEAR 10-24-87					2b HOUR 1500^{3P}					
3 SEX Female			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 4 15			6 AGE (IN YEARS LAST BIRTHDAY) 71			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD						
10 CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash., Adventist Hospital							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY Mont. 13c CITY OR TOWN Kensington					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET ADDRESS / ZIP CODE 9508 Cable Dr. 20895					
14 FATHER'S NAME FIRST MIDDLE LAST George Goldberg					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Gilray										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 212-68-2422			17 INFORMANT Thomas Garrahan			ADDRESS 7782 Fern Oak Ct. VA 22111						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Adenocarcinoma of Lung										6 months					
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 9/12 , 19 87 , to 10/24 , 19 87 that (I) (we) last saw the deceased alive on 10/24/87 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.															
22b SIGNATURE Alfred Munzer MD								DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/25/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Munzer MD								22e ADDRESS 7600 Carroll Ave. Takoma Park Md 20912							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 10/28/87		23c NAME OF CEMETERY OR CREMATORY Parklawn Cem.				23d LOCATION CITY OR TOWN COUNTY STATE Rockville, MD					
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016								25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE John S. ...					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (PRINT)			2a DATE OF DEATH			2b HOUR			
FIRST MIDDLE LAST DEMOND DEAN Earl GAY			MONTH DAY YEAR 10 26 87			10:03A M			
3 SEX MALE		4 RACE Black		5. DATE OF BIRTH April 15, 1960 04 15 60		6 AGE (IN YEARS LAST BIRTHDAY) 27 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TOPEKA KANSAS		7b CITIZEN OF WHAT COUNTRY? U.S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, CO. MD			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 342 HIGHVIEW TERRACE, #104	
14 FATHER'S NAME FIRST MIDDLE LAST LEE calvin GAY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERA EUBES		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b SOCIAL SECURITY NO. 214 82 1627		17 INFORMANT 342-A Highview Terrace, #104; Anita Nadine Gilbert-Jones Gay (wife) 21701							
18 CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				Frederick, Maryland				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: sickle cell disease									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Apr. 1, 1983, to Oct. 26, 1987, that (I) (we) lost saw the deceased on Oct. 26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we lost the body, we did not view the body after death).									
22b SIGNATURE G. Peter Pushkas MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/27/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) G. Peter Pushkas		22e ADDRESS 11510 Old Georgetown Rd. Rockville, Md							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 31, 1987		23c NAME OF CEMETERY OR CREMATORY Washington National		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G.Co., Maryland			
24 FUNERAL DIRECTOR NAME LATNEY's Funeral Home		ADDRESS 3831 Georgia Avenue, N.W.; Washington, D.C. 20011		24a DATE REC'D. BY REGISTRAR NOV 09 1987		24b REGISTRAR'S SIGNATURE John S. Gordon			

069766 OCT 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (Type in print) Donald Norman George			2a. DATE OF DEATH MONTH DAY YEAR October 19, 1987			2b. HOUR 3:30 PM					
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS		IF UNDER 1 YEAR MONTH DAY		IF UNDER 1 YEAR MONTH DAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carrier			12b. KIND OF BUSINESS OR INDUSTRY US Postal Sv.		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3812 Delano Street 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Norman John George			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Myers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Dorothy B. George (wife) 3812 Delano St. Wheaton Md. 20902							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chron respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old chest trauma</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Colony Removal - anti</u>											
19a. DATE OF OPERATION <u>NA</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:00 AM 10/19/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) <u>MVA</u>							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. LOCATION OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) <u>see hospital records</u>		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <u>Rockville, Maryland</u>							
22a. I certify that (1) (this hospital) attended the deceased from <u>10/19/87</u> to <u>10/19/87</u> that (1) (we) last saw the deceased <u>above</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <u>Elliot Goldstein</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>10/20/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elliot Goldstein				22e. ADDRESS <u>9410 OLD GEORGETOWN Rd BETH</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland					
24. FUNERAL DIRECTOR <u>Son Wheeler Funeral Home, Inc.</u> 1331 Rockville Pike Rockville, Md. 20852				25a. DATE OCT 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rudner</u>					

CLEARED BY DR. H.C. MAYLE 10/21/87

MEDICAL CERTIFICATION

08-00000-000000000000

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

a

James

G.

George

October 21, 1987

12:01 M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS LAST BIRTHDAY)

7 IF UNDER 1 YEAR

8 UNDER 12 HRS

Male

Caucasian

October 28, 1923

63

YRS

MONTHS

DAYS

HOURS

MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b CITIZEN OF WHAT COUNTRY?

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Pennsylvania

United States

Montgomery County

MD

10 CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b KIND OF BUSINESS OR INDUSTRY

Rockville

Shady Grove Adventist Hospital

Assistant Supervisor

Transit Auth.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e STREET ADDRESS / ZIP CODE

New York

Queens

Glendale

YES ☒ NO ☐

79-43 77th Road/ 11385

14 FATHER'S NAME

FIRST

MIDDLE

LAST

15 MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Clarence

George

Annette

Coon

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b SOCIAL SECURITY NO

17 INFORMANT

ADDRESS

Yes

WWII

188-12-2424

Mrs. Loretta George, Wife, Same as #13

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Hepatic Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Shock

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Chronic Renal Failure, Acute Respiratory Failure

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 8 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a I certify that (i) (this hospital) attended the deceased from 10/20 to 10/21, 1987, and that in my opinion death occurred on the date and hour and from the causes stated above; (ii) (I) did not view the body after death

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

10-21-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

RAYMOND BOSS

3941 Ferrara

Wheaton 20906

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

23b DATE

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

COUNTY

STATE

Burial

26, 1987

National Cemetery

Pinelawn

New York

24 FUNERAL DIRECTOR

25a DATE REC'D BY REGISTRAR

25b REGISTRAR'S SIGNATURE

300 W. Montgomery Avenue, Rockville, MD.

OCT 26 1987

Raymond Boss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 9 9 4 5

FOR
1 - STATE
REGISTRAR

REG. NO.

069484 007 2387

DECEASED NAME (TYPE OR PRINT) Baby Boy		FIRST Middle LAST Ghodsi		2a. DATE OF DEATH MONTH DAY YEAR 10/8/87		2b. HOUR 1800 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10/8/87		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 7/37	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Holy Cross-Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE MD		13b. CITY OR TOWN Rockville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12121 Village Sq. #402 20755	
14 FATHER'S NAME FIRST Middle LAST Mohammad N. Ghodsi		15 MOTHER'S MAIDEN NAME FIRST Middle LAST Katyapun Sahelbgharani					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Mohammad N. Ghodsi (father) same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) extreme Prematurity DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> A) WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 8 19 87 to Oct 8 19 87, that (I) (we) lost saw the deceased alive on Oct 8 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE mchou		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) margaret m. chou		22e. ADDRESS Holy Cross Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25c. REGISTRAR'S SIGNATURE Oct 21 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

70-63-700-404030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and procedure followed.

MEDICAL CERTIFICATION

999999

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) RICHARD ALBERT GIBSON			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 5, 1987		2b HOUR 3:45 a.m.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR OCTOBER 5, 1940		6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Altoona, P.A.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b KIND OF BUSINESS OR INDUSTRY Self Employed
13a STATE OF RESIDENCE DISTRICT OF COLUMBIA		13b COUNTY WASHINGTON	13c CITY OR TOWN WASHINGTON	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3900 CONNECTICUT AVE, NW 20008
14 FATHER'S NAME FIRST MIDDLE LAST Willis Gibson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tilda Jane Wirt		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 166-32-3399		17 INFORMANT MR. EDWARD LEE GLOVER SAME AS DECEASED			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>INTRACTABLE GASTROINTESTINAL BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ACQUIRED IMMUNODEFICIENCY SYNDROME</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 36 HOURS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JULY 21</u> 19 <u>86</u> , to <u>OCTOBER 5</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 5</u> 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b SIGNATURE <i>Sharilyn K. Stanley</i>				22c DATE SIGNED 10-5-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SHARILYN K. STANLEY				22e ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MD. 20892	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-6-87		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e FUNERAL DIRECTOR U. William Lee's Sons Company 300 4th St. N.E. Washington, D.C. 20002			
23f DATE REC'D BY REGISTRAR OCT 15 1987				23g REGISTRAR'S SIGNATURE <i>Davidson</i>	

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LIBRARY

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070775 NOV

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sharon King Gilley		2a. DATE OF DEATH MONTH DAY YEAR 10 30 87		2b. HOUR 3:40pm	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1954		6. AGE (IN YEARS LAST BIRTHDAY) 32	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Montgomery Cty. Bus Aid		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Md.	
13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7919 Spiceburg Circle		14. FATHER'S NAME (FIRST MIDDLE LAST) Vernon King		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Olive Barnett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO 215 62 5016		17. INFORMANT (Brother) ADDRESS John Neal, Jr. Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC OVARIAN CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 18 months
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from March 1986 to October 1987 that (2) we last saw the deceased alive on 10/30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Type) (did) (did not) view the body after death		22b. SIGNATURE Ralph Boccia	
22c. DATE SIGNED 10/30/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Boccia, MD		22e. ADDRESS 14801 Physicians Ln #271 Rowville MD	
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 11/3/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (CITY OR TOWN COUNTY STATE) Rockville Mont. Md.		24. FUNERAL DIRECTOR Hines, Rinaldi 11800 New Hampshire Ave. S.S., Md.		25a. DATE REC'D. BY REGISTRAR NOV 3 1987	
25b. REGISTRAR'S SIGNATURE 1.1. Rinaldi					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070775 NOV-4-67

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WASH. COTTON INC.

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069128 OCT 20-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ELLEN CAROLYN GLEUE			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 13 1987		2b HOUR 10:00 P M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR MAY 26 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 23 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND			13b COUNTY ST. MARY'S	13c CITY OR TOWN HOLLYWOOD	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST HENRY F. EICHLIN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA M. MEISSNER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 174-10-7389		17 INFORMANT ADDRESS CARROLL L. PALMER, 5 KENDON DRIVE, EASTON, PA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from AUGUST 27, 19 87, to OCTOBER 13, 19 87, that (I) (we) last saw the deceased alive on OCTOBER 13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE J. A. Swenson		DEGREE MD		22c DATE SIGNED 19 OCT 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. A. SWENSON, LT, MC, USNR		22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 10-20-87	23c NAME OF CEMETERY OR CREMATORY EASTON CEMETERY		23d LOCATION (CITY OR TOWN) STATE EASTON, NORTHAMPTON, PA.	
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, MD.		25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE John Swenson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

000 150 051 200

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. FOR
STATE
REGISTRAR

2. BASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

3a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

Mona

Christine Godwin

Oct. 24 87

1820 M

3 SEX

Female

4 RACE

Caucasian

5 DATE OF BIRTH

July 21, 1915

6 AGE (IN YEARS (LAST BIRTHDAY))

72

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 1 YEAR

HOURS MIN

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Tennessee

7b CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County, MD

10 CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales

12b KIND OF BUSINESS OR INDUSTRY

Drug Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Gaithersburg

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

939 Clopper Road #T-3 20878

14 FATHER'S NAME

FIRST

Charles

MIDDLE

Leon

LAST

Walls

15 MOTHER'S MAIDEN NAME

FIRST

Mae

MIDDLE

LAST

St. John

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

400-22-6391

17 INFORMANT

Rene Bellandi

933 Clopper Road A-3

Gaithersburg, Md. 20878

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiovascular Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Renal Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Congestive heart failure, Anemia, COPD

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NO WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) (this hospital) attended the deceased from 10/16/87 to 10/24/87 that (we) last saw the deceased alive on 10/24/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.

22b SIGNATURE

D. Shumaker, MD

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c DATE SIGNED

10/25/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

DOUGLAS R. SHUMAKER, MD.

22e ADDRESS

615 W. MONTGOMERY AVE.

ROCKVILLE, MD 20850

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

Oct. 27, 1987

23c NAME OF CEMETERY OR CREMATORY

Gate of Heaven Cem.

23d LOCATION

CITY OR TOWN

Silver Spring, Maryland

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME, Rockville, Inc.

24b NAME OF FUNERAL HOME/

300 West Montgomery Ave. Rockville, Maryland 20850

25a DATE REC'D BY REGISTRAR

OCT 27 1987

25b REGISTRAR'S SIGNATURE

Julia Gordon-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonized pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050070 OCT 29 1971

RECEIVED
FBI
OCT 29 1971
FBI

050070 OCT 29 1971

070182 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LBC

L.

GOLDFARB

2a. DATE OF DEATH

MONTH

DAY

YEAR

OCTOBER 23, 1987

2b. HOUR

8:10p^m

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

SEPTEMBER 22, 1920

6. AGE (IN YEARS LAST BIRTHDAY)

67

7. UNDER 1 YEAR

MONTHS

8. UNDER 24 HRS

HOURS

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

NEW YORK CITY

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

SUBURBAN HOSPITAL

12a. USUAL OCCUPATION

HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY

HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

MONTGOMERY

13c. CITY OR TOWN

SILVER SPRING

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

200 HANNES ST. (20901)

14. FATHER'S NAME

SAMUEL

MIDDLE

LOEWY

15. MOTHER'S MAIDEN NAME

SYLVIA

MIDDLE

LEVY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

578-16-4338

17. INFORMANT

DAUGHTER MARYLAND 20901
JANET WINELAND; 200 HANNES ST.; SILVER SPRING18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

End stage Renal Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the
underlying cause last

(b) Diabetes

DUE TO, OR AS A CONSEQUENCE OF

(c)

>10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/23 19 87 to 10/23 19 87 that (we) last saw the deceased alive on 10/23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (which) did not, view the body after death)

22b. SIGNATURE

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF ☐
PHYSICIAN DIRECTOR PHYSICIAN

22c. DATE SIGNED

10/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DAVID B. KESSLER

22e. ADDRESS

10620 GEORGETOWN AVE. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

10/25/87

23c. NAME OF CEMETERY OR CREMATORY

MT LEBANON CEMETERY

23d. LOCATION

ADELPHI

COUNTY

PG MARYLAND

24. FUNERAL DIRECTOR

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC
1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852

25a. DATE REC'D BY REGISTRAR

OCT 28 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

70069 OCT 29 87

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack M. GORDON			2a. DATE OF DEATH MONTH DAY YEAR October 18, 1987		2b. HOUR 7:30 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTH DAY YEAR IF UNDER 24 HRS HOUR MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manufacturer	12b. KIND OF BUSINESS OR INDUSTRY Women Apparel	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 028 03 5147		17. INFORMANT ADDRESS Rachel Simon, Daughter, Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Obstructive Pulmonary Disease					Years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION -----		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20a. AUTOPSY? YES <input type="checkbox"/> XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES N/A NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) N/A-----		
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> N/A AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -----		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -----	
22. I certify that (1) XXXXXX attended the deceased from 10/18/87 19____ to 10/18/87 19____ that (1) XX last saw the deceased alive on 10/18/87 19____ and that in (my) XX opinion death occurred on the date and hour and from the causes stated above. (2) XX did XXXXXX view the body after death.					
23a. SIGNATURE <i>Penny Bisk</i> DEGREE				23c. DATE SIGNED 10-18-87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) Penny Bisk, M.D.				23e. ADDRESS 10313 Georgia Ave., Silver Spring, MD 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-19-87	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, PG Co., MD
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CORP., 8655 Georgia Avenue				25. DATE REC'D. BY REGISTRAR OCT 26 1987	
25b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>					

069134 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT TYLER GORMAN			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 13 1987		2b HOUR A M 8:05
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR NOVEMBER 30 1913		6 AGE (IN YEARS LAST BIRTHDAY) YRS 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec. Engineer		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY PRINCE GEO'S	13c CITY OR TOWN COLLEGE PARK	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 5207 PADUCAH ROAD 20740
14 FATHER'S NAME FIRST MIDDLE LAST James Gorman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jesse Tyler			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1962	17 INFORMANT ADDRESS MARIE C. GORMAN, 5207 PADUCAH ROAD, COLLEGE PARK			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC GASTRIC CARCINOMA		MD 20740
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from **OCTOBER 5** 19 **87**, to **OCTOBER 13** 19 **87**, that (I) (we) last saw the deceased alive on **OCTOBER 13** 19 **87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you (we) did not view the body after death, so state.)

22b SIGNATURE <i>S. Curiale</i>	22c DATE SIGNED 14 OCT 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. CURIALE, LT, MC, USN	22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-16-87	23c NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24a FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS FUNERAL HOME, P.A.		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 19 1987	
4739 Baltimore Ave., Hyattsville, Maryland			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 above says injury or other traumatic event, the medical examiner must be notified promptly.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

069810 OCT 27 1987

1. DECEASED NAME (TYPE OR PRINT) Thomas - Graham				2a. DATE OF DEATH MONTH DAY YEAR 10-18-87				2b. HOUR 4 p.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 07 38		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Partner-International Consulting		12b. KIND OF BUSINESS OR INDUSTRY Firm			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 727-A Delaware Ave., S.W. 20024	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas - Graham, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie-Louise Baird					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-US Army		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-1958		17. INFORMANT Wendell V. Graham (Wife)		18. ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 years</u> <u>20 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>DIABETIC KETO ACIDOSIS; CHRONIC RENAL FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>10/15</u> 19 <u>87</u> to <u>10/18</u> 19 <u>87</u> that (2) <u>last</u> saw the deceased alive on <u>10/16</u> 19 <u>87</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> viewed, did not view the body after death)									
22a. SIGNATURE <u>Carl I. Schoenberger</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>10/19/87</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CARL I. SCHOENBERGER</u>				22e. ADDRESS <u>4701 RANDOLPH RD ROCKVILLE</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, District of Columbia			
24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002				25a. DATE REC'D BY REGISTRAR <u>10/19/87</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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BP

69774 OCT 26 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Doris H. Gray			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1987			2b. HOUR 1:45 pm			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY G.C. Murphy	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12025 Bluehill Rd. Wheaton 20902	
14. FATHER'S NAME FIRST MIDDLE LAST James A. Hamilton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Lechliden			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 220-12-2571			17. INFORMANT James A. Hamilton, Jr. 9909 Tenbrook Dr. Silver Spring, Md. 20901			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ovarian cancer with liver metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 9 mos			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 19 86 to October 19 87 that (I) [we] last saw the deceased alive on 10-17 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) [we] (did) (did not) view the body after death.									
22b. SIGNATURE Kai-Yin Yeung, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin YEUNG, M.D.			22e. ADDRESS 8926 Woodland Rd #201 Clinton, MD 20735						
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

071244 NOV-90

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29950

REG NO

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Abraham Greenberg</i>		2a DATE KNOWN OF DEATH ESTI MATED <i>Oct 31, 1987</i>		2b HOURS OF DAY <i>3:45</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Feb 17 1907</i>	6 AGE (IN YEARS) (LAST BIRTHDAY) <i>80 YRS</i>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR TERRITORY) <i>New York</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>		12a USUAL OCCUPATION (TYPE OR WORK) <i>Merchant</i>	
13a STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spg</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Hirsch Greenberg</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dora Gitter</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>	
16b SOCIAL SECURITY NO. <i>109-09-2953</i>		17 INFORMANT <i>Albert J. Kliman Silver Spring, Maryland</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>					
19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. <i>Regt</i>		DATE SIGNED <i>Nov 1, 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M. D. 1919 Seminary Road, Silver Spring, Maryland</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>11/2/1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>District of Columbia</i>	
23d LOCATION CITY OR TOWN <i>Washington</i>		23e COUNTY <i>District of Columbia</i>		23f STATE <i>D.C.</i>	
24 DONALD R. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a DATE REC'D. BY REGISTRAR <i>NOV 04 1987</i>	

DIVISION OF VITAL RECORDS, 201 W. PATTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PATTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
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UNCLASSIFIED

FBI NOTED 5-02

070434 NOV-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 29957

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RENA G. GREENBERG			2a. DATE OF DEATH MONTH DAY YEAR October 26, 1987		2b. HOUR 12:30a ^{PM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13, 1916		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10500 Rockville Pike, #925		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Levbarg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie (Unknown)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-42-6453		17. INFORMANT Potomac, Md 20854		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> 19 <u>87</u> to <u>10/26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SKILL RATING <u>Mar Schneider, MD</u>				22c. DATE SIGNED Oct. 27, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN SCHNEIDER, M.D.				22e. ADDRESS 12001 Ferrara Avenue, Wheaton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/87		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25. DATE REC'D BY REGISTRAR OCT 30 1987		26. REGISTRAR'S SIGNATURE <u>Julia Decker-Rudolph</u>		
1170 Rockville Pike; Rockville, Md. 20852		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax, Va.				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OCT 30 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RALPH BEERY GREENE			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 14 1987			2b HOUR MIN 12:34 A			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 8 1917		6 AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) CIVIL ENGINEER		12b KIND OF BUSINESS OR INDUSTRY Construction	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY QUEEN ANNE		13c CITY OR TOWN QUEENSTOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE RT 1, BOX 246C6 21658	
14 FATHER'S NAME (FIRST MIDDLE LAST) HAMPTON R. GREENE				15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) TRACY ELIZABETH RODEFFER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 1942-1946 577-10-3235		17 INFORMANT ADDRESS VIRGINIA W. GREENE, RT 1, BOX 246C6,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) QUEENSTOWN, MD 21658 METASTATIC CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 21 19 87 to OCTOBER 14 19 87 that (I) (we) last saw the deceased alive on OCTOBER 14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Edward P. Fox						DEGREE M.D.		22c DATE SIGNED 14 Oct. 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT, MC, USNR						22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a BURIAL, CREMATION, REMOVAL (IF RELEVANT) Cremation		23b DATE Oct. 15, 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d LOCATION (CITY OR TOWN COUNTY STATE) Suitland, Prince George's, Md.			
24 FUNERAL DIRECTOR NAME Barton Funeral Home James H. Barton, Jr., Centreville, Md. 21617						25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rudman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, informed medical examiner must be notified of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16-60M 7-84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Lewis R. Greenidge				2a. DATE OF DEATH MONTH 10 DAY 13 YEAR 87		2b. HOUR 7:20 PM	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH 3 DAY 14 YEAR 21		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a BIRTHPLACE (COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Silver Spring MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housing Councilor		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.		13b COUNTY Mont.		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Arnold MIDDLE Greenidge LAST Greenidge		15 MOTHER'S MAIDEN NAME FIRST Myra MIDDLE Gittens LAST Gittens		13e STREET ADDRESS / ZIP CODE 1205 Forest Glen Road 20901			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO WW II 061-16-5606		17 INFORMANT Enid M. Greenidge 1205 Forest Glen Rd.			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) COPD DUE TO, OR AS A CONSEQUENCE OF: (c) Acute 8 yrs						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from 10/14/87 to 10/13/87 and that (my/our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (could) (could not) view the body after death.				19 84 to 10/13 19 87 the (1) (we) lost			
22b SIGNATURE Isa Taubes				22c DATE SIGNED 10/13/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Isa Taubes				22e ADDRESS 10307 Georgia Ave. Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-16-87		23c NAME OF CEMETERY OR CREMATORY Lee Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.	
24 FUNERAL DIRECTOR NAME T. C. Pinckney ADDRESS Spangler Funeral Home 524 - 8th St., N. E.				25a DATE REC'D. BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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071130 NOV-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN GREENSPAN			2a DATE OF DEATH MONTH DAY YEAR OCT 31, 1987		2b HOUR 11:15^{a.m.}			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MAY 8 1912		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 GRANVILLE DR. SSPG, MD.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIST		12b BUSINESS OR INDUSTRIAL NATIONAL BUREAU OF STANDARDS		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.			13b COUNTY MONTG.		13c CITY OR TOWN SSPG.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST BARNETT GREENSPAN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE HACKASAY				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO. 218-38-8195			17 INFORMANT 12 GRANVILLE DR. SSPG, MD. MRS. LILLIAN GREENSPAN (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) metastatic End Stage Carcinoma of Lung 1982 (5 yrs) DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 2/21 19 87 to 10/31 19 87 that (I) (we) last saw the deceased alive on 2/21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE John E. McKnight MD				22c DATE SIGNED 11/2/87		22d PHYSICIAN'S NAME (TYPE OR PRINT) John E. McKnight MD		
22e ADDRESS 2121 PENN. AVE N.W. WASH, D.C.				23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				
23b DATE NOV-3-87		23c NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ADELPHI MD.				
24 FUNERAL DIRECTOR NAME DANZANSKY - GOLDBERG MEM CHPS.		24b DATE REC'D BY REGISTRAR NOV 06 1987		24c REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Minnie Bertha Gregory			2a DATE OF DEATH MONTH DAY YEAR October 19, 1987		2b HOUR 9:15 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR September 4, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist-Secretary	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Benedict L. Wheeler		15 MOTHER'S MAIDEN NAME FIRST MIDDLE Virginia C. (Unavailable)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 579-60-1311		17 INFORMANT (Son) Frederick G. Gregory ADDRESS 12401 Village Square Terrace Rockville, Md. 20852	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ARTERIO SCLEROTIC VASCULAR DISEASE					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NO, SEE MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from FEB 15, 1986 to OCT 19, 1987 that it last saw the deceased alive on OCT 19, 1987 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)					
22b SIGNATURE Walter E. Goetz MD				DEGREE MD	22c DATE SIGNED 19 OCT 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD				22e ADDRESS 2709 SHOREFIELD RD WHEATON MD 20902	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/21/87	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781			25 DATE REC'D BY REGISTRAR OCT 26 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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WILKINSON



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069853 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG NO

2a DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

SUGRU

Ute

GREIS

2b DATE OF DEATH

MONTH

DAY

YEAR

October 17, 1987

2b HOUR

11:25 am

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

MONTH

DAY

YEAR

October 31, 1936

6 AGE (IN YEARS LAST BIRTHDAY)

50

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10 CITY OR TOWN OF DEATH

Wheaton

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2606 Fenimore Road

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS OR
INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Wheaton

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

2606 Fenimore Road 20902

14 FATHER'S NAME

Paul

MIDDLE

LAST

Noback

15 MOTHER'S MAIDEN NAME

Charlotte

FIRST

MIDDLE

LAST

Grunwald

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO

577-52-5955

17 INFORMANT

ADDRESS 2606 Fenimore Road

Franz L. Greis (Husband) Wheaton, Md. 20902

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

HEART FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the
underlying cause last

(b) FLUID + ELECTROLYTE IMBALANCE

3 WKS

DUE TO, OR AS A CONSEQUENCE OF

(c) SCHWANNOMA - MASSIVE BULK + METS 10 YRS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

PARAPLEGIC - S/P DEBULKING - S/P CORDOTOMY

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 (b) IF APPROPRIATE)

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (1) this hospital attended the deceased from 11/19 1986 to 10/17 1987 that (2) we last
saw the deceased alive on 10/15 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (3) we (I) did (did not) view the body after death.

22b SIGNATURE

Richard P. Delaney, M.D.

DEGREE

ATTENDING MEDICAL STAFF
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22c DATE SIGNED

10/19/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Richard P. Delaney, M.D.

22e ADDRESS

4323 Havard Street, silver Spring, Md. 20906

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10/21/87

23c NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d LOCATION

Brentwood P.G. Maryland

24 FUNERAL DIRECTOR

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781

25a DATE REC'D. BY REGISTRAR

OCT 26 1987

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, if applicable, by the funeral director, page 3 should be detached for use on the burial or cremation permit. Then please reinsert certified copies of pages 1 and 2 and send by first class mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner will be contacted at once.

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2002-11-01 10:10:00

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 29963

FOR
1 - STATE
REGISTRAR

REG NO

069187 OCT 20 87

DECEASED NAME (TYPE OR PRINT) Bertie W. GRIMES			2a DATE OF DEATH MONTH DAY YEAR October 12, 1987		2b HOUR 5:00 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 23805 Woodfield Rd 20879	
14 FATHER'S NAME FIRST MIDDLE LAST William Franklin Duvall		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett E. Purdum			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215-74-0680	17 INFORMANT Janie E. Hawkins,		ADDRESS Item 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Senility</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Atherosclerosis - Gen'l.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u> <u>Years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>19 47</u> to <u>Oct. 12</u> 19 <u>87</u> that I <u>have</u> last saw the deceased alive on <u>Sept. 9</u> 19 <u>87</u> and that <u>an</u> (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. <u>True</u> (did not) view the body after death.					
22b SIGNATURE <u>Jack Schumacher M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Oct. 12, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.		22e ADDRESS 105 Russell Ave., Gaithersburg, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 14, 1987	23c NAME OF CEMETERY OR CREMATORY Wesley Grove		23d LOCATION CITY OR TOWN COUNTY STATE Woodfield, Montgomery, Md.
24 FUNERAL DIRECTOR <u>Orin L. Molesworth, P.A.,</u>		ADDRESS <u>Danascus, Md.</u>		25a DATE REC'D BY REGISTRAR OCT 16 1987	
				25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

10 06 130 131 83 1

10 06 130 131 83 1

October 13, 1907

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.

I am sorry to hear that you are having trouble with your machine. I will try to get it fixed for you as soon as possible.

I am sure that you will be satisfied with the results. I will let you know when it is ready.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

Very truly yours,
J. H. [Name]

Enclosed find the bill for the work done on your machine. I am sure that you will be satisfied with the results.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized page 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified directly.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

2a. DECEASED NAME (PRINT OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Mary C GRUBBS						10 - 19 - 87				2:14P M	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR 12 16 16			70 Years YRS			MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Wash. D.C.		USA					Montgomery County MD				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park,			Washington Adventist Hospital			Nurse-Retired					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Prince Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1912 Erie St. #201, 20783		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Michael O'Connor			Bessie Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
N/A			579 03 4376A			1911 Erie St. Hyattsville, Md. Michael Grubbs (Son)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PRIMARY VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY ARTERY DISEASE + HTN DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE DIABETES MELLITUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 10/19/87 to 10/24/87, that (1) (we) last saw the deceased alive on 10/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did not view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
CHARLES M. BENNER, MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
CHARLES M. BENNER, MD			1161 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			10/22/87		PARKLAWN CEMETERY			Rockville Mont. Md.			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE								
HINE, RINALDI			11800 New Hamp Ave. S.S. Md. OCT 27 1987 Julia Davidson-Randall								

BP

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18-05-100 080050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose m Guarella			2a DATE OF DEATH MONTH DAY YEAR 10-18-87		2b HOUR 0450 AM						
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10-13-11		6 AGE (IN YEARS LAST BIRTHDAY) 76		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS		8 IF UNDER 24 HRS HOURS MIN. YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash.D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) Personnel Fed.Gov't.		12b KIND OF BUSINESS OR INDUSTRY Navy Yard			
13a STATE Md.			13b COUNTY Mont.		13c CITY OR TOWN Burtonsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 14617 OldColumbia Pike 20866		
14 FATHER'S NAME FIRST MIDDLE LAST Matteo Dantuono			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Santa Norchio			17 INFORMANT ADDRESS Angelo Guarella (Husband) Same as 13E					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A			16b SOCIAL SECURITY NO. 578 07 2325								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) prolonged cancer lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Oct 17 1987 to Oct 18 1987 , that (I) (we) last saw the deceased alive on Oct 17 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b SIGNATURE Martino O. Weltz						DEGREE			22c DATE SIGNED 10/18/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Martino Weltz						22e ADDRESS 7525 Greenway Ct Drive Greenbelt MD 20770					
23a BURIAL, CREMATION, REMOVAL SPECIES Burial			23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.			
24 FUNERAL DIRECTOR Hines/Rinaldi						25a DATE REC'D BY REGISTRAR OCT 20 1987			25b REGISTRAR'S SIGNATURE John Davidson		

BP

18 OCT 1951

7

SECRET

OCT 30 1951

070838 NOV 587

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		FIRST LUANNA		MIDDLE Eaton	LAST HABERMEHL	2a. DATE OF DEATH October 22, 1987		2b. HOUR 6:48A M	
1. RECEIVED NAME (TYPE OR PRINT)		3 SEX Female		4 RACE White		5. DATE OF BIRTH Oct. 26, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b KIND OF BUSINESS OR INDUSTRY Federal Govt.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1622 Maydale Drive 20904	
14 FATHER'S NAME FIRST MIDDLE LAST James Eaton		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Westfall		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-84-1609		17 INFORMANT (Son) ADD 1622 Maydale Drive Russell Habermehl, Jr. Silver Spring, Md.	
MEDICAL CERTIFICATION		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Clinical Septicemia, Undigested Food</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (the hospital) attended the deceased from <i>Oct 21</i> 19 <i>87</i> to <i>Oct 22</i> 19 <i>87</i> that (1) (we) last saw the deceased alive on <i>Oct 21</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) (did not) view the body after death.									
22b SIGNATURE <i>Thomas Dooley, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <i>Oct 22, 1987</i>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Dooley, M.D.		22e ADDRESS <i>17904 GEORGIA AVE CRNOY, MARYLAND 20732</i>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/26/87		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24 FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a DATE REC'D. BY REGISTRAR NOV 04 1987		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
 1 - STATE
 REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT) JAMES EDISON HANEY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 19 1987		2b HOUR 9:00 P M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JANUARY 3 1919		6 AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b KIND OF BUSINESS OR INDUSTRY U.S.M.C.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE VIRGINIA	13b COUNTY FAIRFAX	13c CITY OR TOWN FALLS CHURCH	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 7412 LISLE AVENUE 22043	
14 FATHER'S NAME FIRST MIDDLE LAST MALONEY MARSHALL HANEY			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA A. BENSON		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1960	17 INFORMANT ADDRESS GERTRUDE H. HANEY, 7412 LISLE AVENUE, FALLS CHURCH, VA 22046			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) DUE TO, OR AS A CONSEQUENCE OF c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from AUGUST 25 1987 to OCTOBER 19 1987 , that (I) (we) last saw the deceased alive on OCTOBER 19 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>C. L. Blankenship</i>			DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c DATE SIGNED 20 OCT 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) C. L. BLANKENSHIP, CDR, MC, USN			22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/23/87	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION CITY OR TOWN COUNTY STATE Arlington, VA	23e DATE REC'D BY REGISTRAR 10/23/87	
24 FUNERAL DIRECTOR NAME Murphy Funeral Home			25 REGISTRAR'S SIGNATURE <i>[Signature]</i>		
1102 W. Broad St, Falls Church, VA 22046					

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OM / BLS

DAVID

Cl. B. B. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST EDWARD F. HARGAN			2a. DATE OF DEATH MONTH DAY YEAR Oct 17/87		2b. HOUR 3:00 M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 22, 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 15074 HASELMERE COURT 20906	
14. FATHER'S NAME FIRST MIDDLE LAST ARCHIBALD HARGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA DEGNAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 129-10-1559		17. INFORMANT ADDRESS VIOLA K. HARGAN/WIFE/SAME AS 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia, Urinary tract infections.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 19 87 to Oct 19 87 that (I) (we) lost saw the deceased alive on Oct 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Spellman M.D.		DEGREE		22c. DATE SIGNED 10-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. SPELLMAN M.D.		22e. ADDRESS 8830 CAMERON ST. SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT 21, 1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.			25. DATE REC'D BY REGISTRAR OCT 22 1987		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			REGISTRAR'S SIGNATURE [Signature]		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Sallie HARRIS			2a DATE OF DEATH MONTH DAY YEAR Oct 20, 1987			2b HOUR 9:30 PM			
3 SEX FEMALE		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR MAY 16 1917		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b KIND OF BUSINESS OR INDUSTRY Private	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D.C. 13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5100 5th St. N.W. 99999			
14 FATHER'S NAME FIRST MIDDLE LAST Eddie Wilson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Wilson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 242-28-3901		17 INFORMANT ADDRESS Lloyd Harris 5100 5th St. N.W.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a Post Hypoxic Encephalopathy; asthma.									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART I OR PART 2)			
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from 9-29-87 19 87 to 10-20 19 87 that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 10-20 19 87 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.									
22b SIGNATURE John Tauber						DEGREE MD		22c DATE SIGNED 10-21-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber						22e ADDRESS 8218 Wisconsin Ave Bethesda Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/27/87		23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Md.		
24 FUNERAL DIRECTOR NAME R.N. Horton Co. Inc						ADDRESS 600 Kennedy St. N.		25a DATE REC'D. BY REGISTRAR NOV 03 1987	
						25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP 99999
DHMH 10 60M 7/84
(VRA 15, 4)

24142 HARRIS 00-25-1947 24142

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

Female Blue May 1947 15

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Imogene R. Hatfield</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 15 1987</i>		2b. HOUR MIN. <i>4:35 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 5, 1948</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>39</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>13923 Travilah Road 20850</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary or Assistant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Liberty Mutual</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Cosmo E. Palmer</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Eunice Sloan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>577-64-7012</i>	
17. INFORMANT NAME ADDRESS <i>Joyce A. Nicholson (sister) 20878 27 School Dr. Gaithersburg, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Malignant Melanoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) the hospital attended the deceased from <i>May 30</i> 19 <i>87</i> to <i>October 15</i> 19 <i>87</i> that (1) most saw the deceased alive on <i>Sept. 24</i> 19 <i>87</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above <i>above</i> ; (2) my doctor did not view the body after death.							
22b. SIGNATURE <i>Jules R. Lodish</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/16/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jules R. Lodish</i>		22e. ADDRESS <i>2901-OLNEY-Sandy Sp Rd OLNEY Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/20/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Birchlawn Burial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Pearisburg, Virginia</i>	
24. FUNERAL DIRECTOR <i>Wheeler Funeral Home, Inc.</i>		25a. DATE <i>OCT 21 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
25c. ADDRESS <i>1331 Rockville Pike Rockville, Md. 20852</i>							

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove color photograph. Page 1 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other fatal factor, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

9:55

(TYPE OR PRINT)

Marian

T.

Hibbitt

October 31, 1987

a. M.

3 SEX

Female

4 RACE

White

5. DATE OF BIRTH

June 01, 1901

6 AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

IF UNDER 1 YEAR

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

New York

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10 CITY OR TOWN OF DEATH

Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Montgomery General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

3408 Chiswick Court #2E

14 FATHER'S NAME

FIRST

MIDDLE

LAST

Ashley

Thorndike

15 MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Annette

Lowell

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b SOCIAL SECURITY NO

134-36-6845

17 INFORMANT

Anne T. Cover 829 Hollow Tree Ridge Road

ADDRESS Darien, CN 06820

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Chronic myelomonocytic leukemia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 wk

3 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

10/27/87

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

decubitus ulcer debridement

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (a) this hospital attended the deceased from 10/19 1987 to 10/31 1987, that (b) (we) last saw the deceased alive on 10/31 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c DATE SIGNED

10/31/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Catherine M. Chura, M.D.

22e ADDRESS

18111 Prince Philip Drive #312
Olney, MD 20832

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b DATE

Nov. 1, 1987 Metropolitan crematory Alexandria, Virginia

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

Francis J. Collins 500 University Blvd. West

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

NOV 06 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 8 1957

NOV 8 1957

Handwritten notes and signatures, including a large signature in the center and several smaller ones at the bottom.

NOV 8 1957

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29972

REG NO

1- STATE REGISTRAR		2- DATE KNOWN OF DEATH		3- MONTH DAY YEAR		4- HOUR	
5- DECEASED NAME (TYPE OR PRINT)		6- FIRST		7- MIDDLE		8- LAST	
James		John		Higgins			
9- SEX	10- RACE	11- DATE OF BIRTH	12- AGE	13- IF UNDER 1 YR.	14- IF UNDER 24 HRS.	15- DATE PRONOUNCED DEAD	16- MONTH DAY YEAR
MALE	CAUCASIAN	SEPT 14, 1915	72			10/ 3/ 19 87	10:26 a
17- BIRTHPLACE		18- CITIZEN OF WHAT COUNTRY?		19- MARRIED		20- BALTIMORE CITY OR COUNTY OF DEATH	
PENNSYLVANIA		USA		WIDOWED		Montgomery County	
21- CITY OR TOWN OF DEATH		22- NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		23- USUAL OCCUPATION		24- KIND OF BUSINESS OR INDUSTRY	
BRIGHTON		20215 New Hampshire Ave.		PERSONNEL SPECIALIST U.S. COAST GUARD			
25- USUAL RESIDENCE		26- STATE		27- CITY OR TOWN		28- STREET ADDRESS	
FLORIDA				TAMPA		11104 TEE GREEN DRIVE 33612	
29- FATHER'S NAME		30- MOTHER'S MAIDEN NAME		31- INFORMANT		32- ADDRESS	
JAMES A. HIGGINS		NORA FLATLEY		SON		10747 CORDAGE	
33- WAS DECEASED EVER IN U.S. ARMED FORCES?		34- SOCIAL SECURITY NO.		35- JAMES M. HIGGINS/WALK COLUMBIA, MD		21044	
YES		578-28-9255					
36- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Multiple Injuries							
DUE TO, OR AS A CONSEQUENCE OF							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
37- DATE OF OPERATION		38- CONDITION FOR WHICH OPERATION WAS PERFORMED?				39- AUTOPSY?	
						YES [X] NO	
40- EXTERNAL CAUSE WAS		41- TIME OF INJURY		42- HOW INJURY OCCURRED			
UNDERLYING [X] OR CONTRIBUTING [] CAUSE OF DEATH		10:10xx 10/3/ 19 87		driver of auto/dump truck collision			
43- INJURY OCCURRED		44- PLACE OF INJURY		45- LOCATION			
WHILE [] NOT WHILE [X] AT WORK		roadway		20215 New Hampshire Ave., Montgomery, Md.			
46- I certify that I took charge of the remains described above, held an							
Autopsy [X] Inspection [] Inquiry [] and in my opinion							
death resulted from							
Natural cause [] Accident [X] Suicide [] Homicide [] Undetermined manner []							
47- ACTUAL SIGNATURE		48- TITLE (SPECIFY)		49- MEDICAL EXAMINER		50- DATE SIGNED	
Charles P. Kokes, M.D.		Assistant				10/4/87	
51- EXAMINER'S NAME		52- ADDRESS		53- LOCATION			
(TYPE OR PRINT)		Charles P. Kokes, M.D.		111 Penn St., Balto., Md. 21201			
54- BURIAL, CREMATION, REMOVAL		55- DATE		56- NAME OF CEMETERY OR CREMATORY		57- LOCATION	
BURIAL		OCT7, 1987		GATE OF HEAVEN CEMETERY		SILVER SPRING MONTGOMERY MD	
58- FUNERAL DIRECTOR		59- NAME		60- ADDRESS		61- DATE REC'D. BY REGISTRAR	
FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				OCT 14 1987	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW-3, RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

068708 OCT 1987

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BP
CHHH 17
(VR A15 ME (5))

088700 OCT 12 64

UNITED STATES

30% COTTON FIBER

MADE IN U.S.A.



OCT 14 1964

070925 NOV 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Edwin G. Hill			2a DATE OF DEATH MONTH DAY YEAR Oct 23, 87			2b HOUR 1:30AM			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR July 14, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7b HOUR 1:30AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Ashton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1120 Tucker Lane				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b KIND OF BUSINESS OR INDUSTRY None	
13a STATE Maryland		13b COUNTY Montg.		13c CITY OR TOWN Ashton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1120 Tucker Lane 20861	
14 FATHER'S NAME FIRST MIDDLE LAST Clifton Hill			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Tasker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-12-7991		17 INFORMANT ADDRESS Mrs Lula Mae Hill (Wife) Address Same					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma left lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Brain metastases, Atherosclerotic heart disease.</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 19 87</u> to <u>23 Oct 1987</u> that (I) (most) saw the deceased alive on <u>10/8</u> 19 <u>87</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) viewed (I did not view the body after death.							
22b SIGNATURE <u>Donald E. Dillon</u> M.D.				DEGREE M.D.		22c DATE SIGNED 26 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon M.D.				22e ADDRESS 2901 Olney-Sandy Spring Rd, Olney Md			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-29-87		23c NAME OF CEMETERY OR CREMATORY Mutual Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg, Md	
24 FUNERAL DIRECTOR NAME George R. Snowden				24b ADDRESS 246N Washington St Rockville, Md		25a DATE REC'D BY REGISTRAR JUL 29 1987	
25b REGISTRAR'S SIGNATURE <u>June Davidson</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician certify the cause of death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the "Burial Permit." Then please take the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, the autopsy is required, or other traumatic event, the medical examiner must be notified at once.

050025 101-201

RECEIVED
JUN 10 1964
U.S. AIR FORCE
HEADQUARTERS
AFMPC
AFMPC
AFMPC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

DECEASED NAME

FIRST

John

MIDDLE

P.

LAST

Himchak

2a DATE OF DEATH

MONTH

DAY

YEAR

7b HOUR

10

07

87

0946

A

3 SEX

MALE

4 RACE

CAUC.

5 DATE OF BIRTH

MONTH

DAY

YEAR

4

2

27

6 AGE (IN YEARS LAST BIRTHDAY)

7 UNDER YEAR

8 UNDER 24 HRS

60

YRS

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Penn.

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

10 CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Washington Adventist

12a USUAL OCCUPATION

Insurance Broker-Employed

12b EMPLOYER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Md.

13b COUNTY

Mont

13c CITY OR TOWN

S.S.

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

8505 Mayfair Place

20910

14 FATHER'S NAME

John

MIDDLE

LAST

Himchak

15 MOTHER'S MAIDEN NAME

Anna

MIDDLE

LAST

Suche

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

WWII

16b SOCIAL SECURITY NO.

189 20 1853

17 INFORMANT

Ann M. Himchak (Wife) Same as 13E

ADDRESS

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIORESPIRATORY ARREST

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

1 week

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF

(c) MYOCARDIAL INFARCTION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

22a I certify that (I) (this hospital) attended the deceased from September 23 19 87 to Oct 7 19 87 that (I) (we) last saw the deceased alive on Oct 7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/7/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Louis J. Larca

22e ADDRESS

7600 Carroll Ave E Row H Md

23a BURIAL, CREMATION, REMOVAL

Burial

23b DATE

10/9/87

23c NAME OF CEMETERY OR CREMATORY

St. Michael Greek Catholic Cemetery

23d LOCATION

Sheffield, Penn.

COUNTY

STATE

24 FUNERAL DIRECTOR

Hines, Rinaldi 11800 New Hamp. Ave. S.S. Md.

25a DATE RECD. BY REGISTRAR

OCT 13 1987

25b REGISTRAR'S SIGNATURE

Julia Davidson-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the local burial permit. The local burial permit is required for all burials. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

06224 OCT 14 61

9

ON BIDS



069472 OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

29975

1 DECEASED NAME (TYPE OR PRINT) MARY			MIDDLE Louise			LAST HINES			2a DATE OF DEATH MONTH DAY YEAR 10-17-87				2b HOUR 2:00 AM	
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH MONTH DAY YEAR 10 19 04			6 AGE (IN YEARS) (LAST BIRTHDAY) YRS MONTHS DAYS 82				7b HOUR 2:00 AM	
7a BIRTHPLACE (COUNTRY) Washington, D. C.			7b CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10 CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Management				12b KIND OF BUSINESS OR INDUSTRY C & P				
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Olney			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 17729 Queen Elizabeth Drive 20832		
14 FATHER'S NAME FIRST MIDDLE LAST JOHN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO 577-01-2840			17 INFORMANT ADDRESS Mary L. Mowatt Daughter Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (1) (this hospital) attended the deceased from 6-15 , 19 87 , to 10-17 , 19 87 , that (1) (we) last saw the deceased alive on 10-16 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b SIGNATURE T E Howe			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 10-17-87					
22d PHYSICIAN'S NAME (TYPE OR PRINT) TED E. HOWE			22e ADDRESS OLNEY, MARYLAND											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 20, 1987			23c NAME OF CEMETERY OR CREMATORY Arlington National			23d LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia					
24 FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr.			25 DATE RECEIVED BY REGISTRAR BY REGISTRAR'S SIGNATURE OCT 22 1987											
500 University Blvd., W. Silver Spring, Md. 20901														

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

088:15 011230

0011 107100 8002
0011 107100 8002

88

31A 31A 31A

31A 31A 31A

0011 107100 8002

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medicolegal aspect must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO.							
2a DECEASED NAME (PRINT) FIRST MIDDLE LAST DALE O HITCHCOCK					2b DATE OF DEATH MONTH DAY YEAR 10/24/87		2c HOUR 4:20 AM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 8 1952		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 35		7 IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OF FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY Landscaping	
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Germantown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Buel Clayton Hitchcock			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie June Garrett			13e STREET ADDRESS / ZIP CODE 17410 Blackrock Road 20874			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 219-54-6110		17 INFORMANT ADDRESS Buel C. Hitchcock, Germantown, Maryland					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Respiratory Distress Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72°									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a liver failure									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from Oct. 21 , 19 87 to Oct 24 , 19 87 that (1) (we) last saw the deceased alive on Oct 23 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.									
22b SIGNATURE Alison Norris, MD				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10-24-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALISON NORRIS				22e ADDRESS 14915 Braschart Rd. Rockville, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 27, 1987		23c NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Beallsville Mont. Md.			
24 FUNERAL DIRECTOR NAME Barber Funeral Home				ADDRESS Laytonsville, Md. 20879		25a DATE REC'D BY REGISTRAR OCT 28 1987		25b REGISTRAR'S SIGNATURE	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 29977	
1- FOR STATE REGISTRAR										2a DATE KNOWN OF DEATH	
1 DECEASED NAME (PRINT) FIRST MIDDLE LAST Donald Leslie Hitchings										2b DATE KNOWN OF DEATH ESTIMATED 10/16/ 1987 6:10A	
3 SEX Male 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR June 27, 1912 75 YRS 6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 7 IF UNDER 1 YR. 8 IF UNDER 24 HRS.										2c DATE PRONOUNCED DEAD 10/16/ 1987 6:10A	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD											
10 CITY OR TOWN OF DEATH Bethesda 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer 12b KIND OF BUSINESS OR INDUSTRY Military											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY Mont. 13c CITY OR TOWN Bethesda 13d INSIDE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 5600 Knollwood Rd. 20816											
14 FATHER'S NAME FIRST MIDDLE LAST Leslie Hitchings 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Sleeper											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes. WW II 16b SOCIAL SECURITY NO. 209-05-4624 17 INFORMANT ADDRESS Charlotte M. Hitchings Same as # 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Tauber M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 10-16-87											
EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 Wisconsin Ave Bethesda MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 10/21/87 23c NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. 23d LOCATION CITY OR TOWN COUNTY STATE Arl. VA											
24 FUNERAL DIRECTOR'S NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016 25a DATE REC'D BY REGISTRAR OCT 28 1987 25b REGISTRAR'S SIGNATURE											

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DHMH - 17
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edmond D. Hoekstra			2a. DATE OF DEATH MONTH DAY YEAR October 10, 1987			2b. HOUR 8:20AM			
3. SEX White		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR August 1, 1907		6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS.		7. IF UNDER 1 YEAR MONTHS (DATE) HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4316 Clearbrook Lane 20795				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor Relations Expert		12b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4316 Clearbrook Lane 20795	
14. FATHER'S NAME FIRST MIDDLE LAST Dirk Jans Hoekstra			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grietje Zandt			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO 366-07-6844			17. INFORMANT (Wife) Josefa A. Hoekstra. Address: Kensington, M.D. 20795 4316 Clearbrook Ln.						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year 2 Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>September 1, 1970</u> to <u>October 10, 1987</u> that (I) (we) last saw the deceased alive on <u>October 10, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas L. Hartman</u> M.D.						DEGREE M.D.		22c. DATE SIGNED October 10, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Hartman, M.D.						22e. ADDRESS 3301 New Mexico Ave, N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10-11-87		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR J. William Lee's Sons Company 300 4th St. N.E. Washington, D.C. 20002						25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) ARTELIA E HOLMES				2a DATE OF DEATH MONTH DAY YEAR Oct 1 1987		2b HOUR 0343 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 4 1908		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietitian		12b KIND OF BUSINESS OR INDUSTRY College	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Sampson G., Walters				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora House			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT (NAME) ADDRESS Diane Clinansmith 19248 Circle Gate Drive Germantown, Md. 20874			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF, (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF, (c) Massive Left Cerebral Infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours 25 days 25 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, Neurogenic Bladder & Urinary Tract Infection							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 1106 Spring Street, Silver Spring, MD 20910			
22a I certify that (I) (this hospital) attended the deceased from 1 April 1953 to 1 Oct 1987 that (I) (last) saw the deceased alive on 30 Sept 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Russell B. Arnold M.D.				DEGREE MD		22c DATE SIGNED 10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Russell B. Arnold M.D.				22e ADDRESS 1106 Spring Street, Silver Spring, MD 20910			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-5-1987		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				25a DATE REC'D. BY REGISTRAR OCT - 2 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM EN 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR		FOR		29880	
1 DECEASED NAME (TYPE OR PRINT)		FIRSE		MIDDLE	
Ransom Alvin		Holt			
2a DATE KNOWN OF DEATH		ESTI MATED		2b DATE KNOWN OF DEATH	
OCT 15 1987		OCT 14 1987		A.M.	
3 RACE		4 DATE OF BIRTH		5 AGE (IN YEARS)	
M BIK		JAN 22 1965		5 YRS.	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		6b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
S. C.		USA			
9a CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
D.C. Spg		389-2 Bel Me Rd Apt 12			
13a STATE		13b COUNTY		13c CITY OR TOWN	
MD		Monte		D.C. Spg	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
David		Maria		No	
16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
016-12-4835		Maria L. Mosquera/Ex Wife/7671		Laytonia Dr., Gaithersburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper Gastrointestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>None</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John T. Rhines		M.D. Day		OCT 15 1987	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SP)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		10-20-87		Arlington National	
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR	
John T. Rhines Co.,		3015 12th St. N.E., D.C.		20017	

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OCT 19 1987

Julia Sanders-Randall

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR		FOR DECEASED NAME		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
(TYPE OR PRINT)		Dora		Horowitz						Box 7		19		27		1987		3:30 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 4 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	Nov 22 1925		8 YRS.						Oct 27		19		27		1987		3:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH											
Lithuania		U.S.A.		WIDOWED		X		DIVORCED		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		KIND OF BUSINESS OR INDUSTRY													
Tak Park A		Wash. Advent Hosp		Saleswoman		Ladies Wear													
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS									
Maryland		Montg.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		8204 New Hampshire Avenue, #204;											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Louis		Freda																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT															
NO		579-07-7617		Gaithersburg, Md. 20879															
				Rita Liebowitz; Daughter; 20504 Dubois Ct.;															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
				Acute Myocardial Dis															
				(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
None																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
JOHN S. ROGERS, M.D.		M.D. Dr. S. Rogers		OCT 19 1987															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
JOHN S. ROGERS, M.D.		Silver Spring, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		10/11/87		Judean Memorial Gardens		Olney; Montgomery; Maryland													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		OCT 13 1987		Julia Davidson-Randall															
1170 Rockville Pike; Rockville, Md. 20852																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMAL PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
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BP

DHMH - 17
(VR A15 ME (5))

088448 OCT 14 07

Dear Mr. [illegible]
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OCT 13 1907

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY N. HOWARD			2a DATE OF DEATH MONTH DAY YEAR 10 22 87		2b HOUR 2:50 P
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 19, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS MONTH DAYS HOURS MIN.	7b HOUR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL BETHESDA		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreign Service		12b KIND OF BUSINESS OR INDUSTRY State Dept.
13a STATE MD			13b COUNTY Mont.	13c CITY OR TOWN Beth.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Alpheus M. Howard			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois Foster		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 106-30-4900		17 INFORMANT ADDRESS 22090 Norman Howard 11500 Fairway Dr. Reston, VA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>TRACHEOBRONCHITIS AND ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ADVANCED PARKINSON'S DISEASE AND ORGANIC BRAIN SYNDROME</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>MAY</u> 19 <u>87</u> to <u>10/22</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.					
22b SIGNATURE <i>[Signature]</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c PHYSICIAN'S NAME (TYPE OR PRINT) IRVING MIZUS, MD		22e ADDRESS 5413 CEDAR LANE #206C, BETHESDA, MD 20814			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/26/87	23c NAME OF CEMETERY OR CREMATORY Reck Creek Cem.		23d LOCATION Wash., DC COUNTY STATE
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a DATE REC'D. BY REGISTRAR OCT 30 1987	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

069892 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Joseph H. Hutchinson			2a DATE OF DEATH MONTH DAY YEAR 10 16 87		2b HOUR 3 45 AM
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR July 9, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	12b KIND OF BUSINESS OR INDUSTRY Local #5	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Rockville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 422 North Horners Lane 20850	
14 FATHER'S NAME FIRST MIDDLE LAST Dallas Hutchinson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Shaw			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b SOCIAL SECURITY NO. 214 03 3353	17 INFORMANT Sister in law ADDRESS Lottie Hutchinson 721 Lincoln Way West Gettysburg, PA 17325			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>extensive coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>obstructive pulmonary disease</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 <u>2087</u> to <u>10-16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>DR. B. J. Jones</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10-16-87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. B. J. Jones / SN Jones</u>		22e ADDRESS <u>809 Ueirs Mill Rd Rockville</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE <u>October 20, 1987</u>	23c NAME OF CEMETERY OR CREMATORY Flower Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE <u>Derwood Maryland</u>
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY Rockville Inc 300 West Montgomery Ave Rockville Maryland			25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Hutchinson

1900

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) JAMES Walter HUTCHISON			2a. DATE OF DEATH MONTH DAY YEAR 10 4 87		2b. HOUR 3:54 p.m.
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR August 28, 1899	6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	
7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD		
10 CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEAR) Administrative	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Hutchison			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Amelia Adie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW I		16b. SOCIAL SECURITY NO. 353-22-3590	17 INFORMANT P.O. Box 8 Barbara A. Thompson Great Mills, Md. 20634		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Monoclonocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Atherosclerotic Cardiovascular disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from <u>9/1/87</u> to <u>10/4/87</u> that it was lost saw the deceased alive on <u>10/2/87</u> and that in my opinion death occurred on the date and hour and from the causes stated above; (2) I <u>did not</u> (did not) see the body after death.					
22b. SIGNATURE <u>Jules R. Lodish</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules R. Lodish, M.D.		22e. ADDRESS 2901 Olney-Sandy Spring Rd Olney, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR OCT 09 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88313 OCT 1967

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Hoa Huynh			2a DATE OF DEATH MONTH DAY YEAR October 04, 1987		2b HOUR 12:55am
3 SEX Male	4 RACE Chinese	5 DATE OF BIRTH MONTH DAY YEAR August 11, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) China	7b CITIZEN OF WHAT COUNTRY? China	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 801 Quince Orchard Blvd. #33.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 801 Quince Orchard Blvd. #33 / 20878
14 FATHER'S NAME FIRST MIDDLE LAST Can Huynh		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		16b SOCIAL SECURITY NO. 217 04 9063	17 INFORMANT (Wife) Can Luu Huynh Same as #13.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic cancer to both lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous cell carcinoma of larynx</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cachexia, Right Pleural effusion, Chronic Tracheostomy</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) XXXXXX attended the deceased from <u>June 09, 1987</u> to <u>October 04, 1987</u> , that (1) XXXX saw the deceased alive on <u>August 21, 1987</u> , and that in (my XXXX) opinion death occurred on the date and hour and from the causes stated above, (1) XXXXXX (did not) view the body after death.					
22b SIGNATURE <i>Donald E. Dillon</i>				22c DATE SIGNED October 5, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e ADDRESS 2901 Laytonsville Rd. Olney, Maryland 20832	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 08, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Suitland/Pr. Georges/Maryland		
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland					

Released By: Francis C. Mayle Deputy Medical Examiner

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 constitute the Certificate of Death after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "b", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DATE REC'D BY REGISTRAR 25 REGISTRAR'S SIGNATURE

OCT 09 1987 *Jula Davidson-Randall*

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4 1/2 IN

MADE IN THE U.S.A.

MADE IN THE U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the top papers (pages 1 and 2) and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (1), it shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR THE STATE REGISTRAR DECEASED NAME FIRST MIDDLE LAST HARRY B. HYMAN									
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug 5 1912		7a DATE OF DEATH MONTH DAY YEAR 10/22/87		7b HOUR 3:20 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12 USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORK ACTIVITIES) Godara Space Agency-Electronic Tech.		13a STATE Md.		13b COUNTY Mont	
13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 16000 Avery Road 20855					
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Hyman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Amanda Hyman		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b SOCIAL SECURITY NO 577 28 1738		17 INFORMANT ADDRESS Doris Hyman (Wife) Same as 13E	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PAEVIUS NON ANCHRONIC CHRONIC HEPATITIS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>2 wks</u> <u>5 YRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>PANCREATIC CARCINOMA, HYPERNEPHROMA, DIABETES</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <u>10/16</u> 19 <u>87</u> to <u>10/22</u> 19 <u>87</u> that I (we) last saw the deceased alive on <u>10/22</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)									
22b SIGNATURE <u>Mark Birns</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/22/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARK BIRNS, MD				22e ADDRESS 411 MEDICAL CENTER PK SUITE 305 ROCKVILLE, MARYLAND 20850					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/25/87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alex. Va.			
24 FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S., Md.				25a DATE REC'D. BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rudolph			

BP

050000 000050

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) RICHARD H JEANNERET		7a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 30 1987		7b. HOUR OF DEATH DAY <input type="checkbox"/> HOUR <input type="checkbox"/> MIN <input type="checkbox"/> 1750	
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 11 17 36	6 AGE (IN YEARS) (LAST BIRTHDAY) YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> 50	IF UNDER 1 YR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTCOMERY County, MD		
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUNBARON HOSPITAL	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Associate Commissioner	12b KIND OF BUSINESS OR SERVICE General Administration		
13a STATE MD		13b COUNTY MONTCOMERY	13c CITY OR TOWN ROCKVILLE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11901 OPEN CT / 20852
14 FATHER'S NAME FIRST Henry MIDDLE A. LAST Jeanneret		15 MOTHER'S MAIDEN NAME FIRST Katherine MIDDLE Moore LAST Moore			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b SOCIAL SECURITY NO 1960-1961		17 INFORMANT Mrs. Janet M. Jeanneret, Wife	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ACUTE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last

(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

UNDER

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR <input type="checkbox"/> A.M. MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 17 P.M. 10 30 1987	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED TO FLOOR
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) STATION MTRC	21f LOCATION CITY OR TOWN METRO CENTER ROCKVILLE COUNTY MONTCOMERY STATE MD
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE Francis C. Mayo		TITLE (SPECIFY) SEPT. MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayo		DATE SIGNED 10/31/87
ADDRESS 8200 Wisconsin Ave Bethesda MD		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE November 3, 1987	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d LOCATION CITY OR TOWN Silver Spring COUNTY Maryland
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD. 20814		25a DATE REC'D. BY REGISTRAR NOV 2 1987	25b REGISTRAR'S SIGNATURE Richard Pumphrey

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST ROBERT JERVIS			2a. DATE OF DEATH MONTH DAY YEAR 10 09 87		2b. HOUR 3:30 PM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR MAY 14, 1905		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		
10 CITY OR TOWN OF DEATH CHERRY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4601 NORTH PARK AVENUE #1703		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRONIC ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY ENGINEERING				
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHERRY CHASE		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4601 NORTH PARK AVE. / 20815				
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JOHN JERVIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BIANCA - QUATTRINI				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 148-07-9654		17 INFORMANT HELEN J. JERVIS (WIFE) SAME AS #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CardioRespiratory arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Disease					10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Heart disease - Mitral and coronary manupg					12 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a mitral valvulopathy 1976, rising fluid myelium						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 1 FOR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 16 , 19 86 , to October 5 , 19 87 , that (I) (we) last saw the deceased alive on October 5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 10/9/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE A. QUIROS MD		22e. ADDRESS 4343 MONTGOMERY AVE. BETHESDA, MD. 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CROMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.CO. MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME 8655 GEORGIA AVE. SIVER SPRING - MD.				
25a. DATE RECEIVED BY REGISTRAR OCT 19 1987						
25b. REGISTRAR'S SIGNATURE [Signature]						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes" in item 18, shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

11-11-87
[Faint, mostly illegible text follows, appearing to be a memorandum or report. Some words like "SUBJECT", "REFERENCE", and "ACTION" are faintly visible.]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Nadine M. Johannesen			2a DATE OF DEATH MONTH DAY YEAR October 18, 1987		2b HOUR 10:15PM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR January 15, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 62	7b BIRTHPLACE (TYPE OR FOREIGN COUNTRY) Michigan
7a BIRTHPLACE (TYPE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13917 Congress Drive		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home		13a STREET ADDRESS 13917 Congress Drive/20853	
14 FATHER'S NAME FIRST MIDDLE LAST Jerome Jelinek		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Signer		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO 309-34-8004		17 INFORMANT ADDRESS Rolf B. Johannesen (Husband) 13917 Congress Drive, Rockville, Maryland 20853		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Woman DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Kidney Failure DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) this hospital attended the deceased from 9/20/87 to 10/18/87 the (1) (we) last saw the deceased alive on 10/19/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (we) did not view the body after death.					
22b SIGNATURE Allan B. Cohan		22c DEGREE M.D.		22d DATE SIGNED 10/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Allan B. Cohan M.D.		22e ADDRESS 13975 Conn. Ave. Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL Cremation		23b DATE October 20, 1987		23c NAME OF CEMETERY OR CREMATORY Montgomery Crematory	
23d LOCATION CITY OR TOWN COUNTY STATE Bethesda Montgomery, Maryland		23e DATE REC'D. BY REGISTRAR OCT 26 1987		23f REGISTRAR'S SIGNATURE [Signature]	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home-Bethesda Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Md.					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

Benjamin Joseph Johnson, III

2a DATE KNOWN OF DEATH ☒ MONTH DAY YEAR 1987
2b MONTH OF ESTI MATED DEATH ☐ MONTH DAY YEAR 1987

3 SEX

4 RACE

5 DATE OF BIRTH

MONTH DAY YEAR

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

7c DATE

PRONOUNCED

DEAD

1987

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

LOUISIANA

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD

10 CITY OR TOWN OF DEATH

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

SECURITY GUARD

12b KIND OF BUSINESS OR INDUSTRY

SVERDRUP

13a STATE

13b COUNTY

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS

9001 Kimerly 20901

14 FATHER'S NAME

MIDDLE

LAST

BENJAMIN

J.

JOHNSON, JR.

15 MOTHER'S MAIDEN NAME

MIDDLE

LAST

LINDA

R.

BAQUET

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

NO

16b SOCIAL SECURITY NO

17 INFORMANT

ADDRESS

438-08-2793

LINDA BAQUET/MOTHER/SAME AS 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Acute Bronchial Asthma

(b)

DUE TO, OR AS A CONSEQUENCE OF

Chronic Bronchial Asthma

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

None

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. 1987

MEDICAL EXAMINER

DATE SIGNED Oct 19 1987

EXAMINER'S NAME

JOHN S. ROGERS

ADDRESS

SEMINARY ROAD SILVER SPRING, MD

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b DATE

OCT 22, 1987

23c NAME OF CEMETERY OR CREMATORY

GATE OF HEAVEN CEMETERY

23d LOCATION

CITY OR TOWN

COUNTY

STATE

SILVER SPRING MONTGOMERY MD

24 FUNERAL DIRECTOR

NAME

FRANCIS J. COLLINS, JR.

25a DATE REC'D BY REGISTRAR

25b REGISTRAR'S SIGNATURE

500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

OCT 22 1987

J. S. Rogers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

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069815 OCT 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) Betty Forbes Johnson		10/11/87		3:40 PM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
		Aug. 15, 1916		71	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) AR	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a STATE MD	13b COUNTY Mont.	13c CITY OR TOWN Beth.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6625 River Rd. 20817	
14. FATHER'S NAME FIRST MIDDLE LAST DeRoska Forbes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Woodson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 158-01-6584		17 INFORMANT ADDRESS Alex., VA 22309	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 10 hrs - standing
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION (CITY OR TOWN, COUNTY, STATE)	
22a I certify that (1) (this hospital) attended the deceased from 10/19 19 87 to 10/11 19 87 that (we) last saw the deceased alive on 10/10 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.					
22b SIGNATURE Paul Kretting DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10-11-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Paul Kretting				22e ADDRESS 2101 Medical Park Dr. Silver Spring Md 20910	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/15/87	23c NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d LOCATION (CITY OR TOWN, COUNTY, STATE) Rockville, MD
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 WI Ave. NW wash., DC 20016				25a DATE REC'D. BY REGISTRAR OCT 26 1987 25b REGISTRAR'S SIGNATURE Julia Gordon-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Burial-transit permits should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any trauma or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Eleanor M. Johnson

2a DATE OF DEATH MONTH DAY YEAR
10-8-87

2b HOUR MIN
9:55 AM

3 SEX
Female

4 RACE
White

5 DATE OF BIRTH MONTH DAY YEAR
Dec. 10, 1892

6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
94 YRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD

10 CITY OR TOWN OF DEATH
Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher

12b KIND OF BUSINESS OR INDUSTRY
Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Gaithersburg 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS / ZIP CODE Russell Avenue / 20877

14 FATHER'S NAME FIRST MIDDLE LAST
Richard Potts Johnson

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma J. Shuff

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b SOCIAL SECURITY NO.
291-09-2316

17 INFORMANT ADDRESS
Mrs. Elleanor Grossnickle, Myersville, Md.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest and Heart Failure 2 Days.
DUE TO, OR AS A CONSEQUENCE OF (b) Duodenal Cancer 6 months
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)
21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from Sept 1980, to Oct 1987, that (I) (we) last saw the deceased alive on 10/5 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE Michael B. Bolognese M.D. DEGREE
22c DATE SIGNED 10/8/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bolognese
22e ADDRESS 19261 Montgomery Village Ave., Gaithersburg

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Bural
23b DATE Oct. 12, 1987
23c NAME OF CEMETERY OR CREMATORY St. Mark's Lutheran Cemt.
23d LOCATION Wolfsville, Frederick, Md.

24 FUNERAL DIRECTOR'S NAME Smith, Keeney and Basford Funeral Home
106 East Church Street, Frederick, Md. 21701
25 DATE REC'D BY REGISTRAR OCT 13 1987
26 REGISTRAR'S SIGNATURE Julie L. Linder

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages 1 and 2. The card should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John P. M. Johnston			2a. DATE OF DEATH MONTH DAY YEAR Oct. 25, 1987		2b. HOUR 6:15 am
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill - Bethesda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Officer	12b. KIND OF BUSINESS OR INDUSTRY US Navy	
13a. STATE ---	13b. COUNTY ---	13c. CITY OR TOWN Washington, D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2118 Bancroft Pl., NW/20008	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Howard Johnston		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorcas Merrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1933-1945	17. INFORMANT ADDRESS Elizabeth K. Johnston, Same address as #13.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>moments</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (s) (this hospital) attended the deceased from <u>10/25/87</u> 19 <u>87</u> to <u>10/25</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/25/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) signed and put my (our) name on the body after death.					
22b. SIGNATURE <u>George C. Buchanan</u> M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Buchanan, M.D.		22e. ADDRESS 3301 New Mexico Ave., #350 Wash, D.C. 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/29/87	23c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, MD
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 WI Ave. NW Wash., DC 20016			25a. DATE REC'D. BY REGISTRAR OCT 30 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18b was any injury, or other traumatic event, the medical examiner must be called at once.

DHMH 16 60M/7/84
(VRA 15, 4)

John	P. W. Johnston	105-101-201	105-101-201
White	White	105-101-201	105-101-201
New York	New York	105-101-201	105-101-201
Bedford	Bedford	105-101-201	105-101-201
Washington, D.C.	Washington, D.C.	105-101-201	105-101-201
Johnston	Johnston	105-101-201	105-101-201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) RAYMOND M. JORDON				2a DATE OF DEATH MONTH 10 DAY 4 YEAR 87				2b HOUR 1833M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH 6 DAY 2 YEAR 17		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tech. Service		12b KIND OF BUSINESS OR INDUSTRY Air Condition	
13a STATE MD		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 208 Lee St. #3, 20877	
14 FATHER'S NAME FIRST Harry MIDDLE J. LAST Jordan		15 MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Elizabeth LAST Jarman		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) W.W.II		16b SOCIAL SECURITY NO 226-12-2299		17 INFORMANT Martha Jordan	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARCINOMA of LUNG DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 min 6 mos.				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) the hospital attended the deceased from 10/4 19 87 to 10/4 19 87 that I viewed last saw the deceased alive on 10/4 19 87 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) viewed (did not) view the body after death.									
22b SIGNATURE Carl I. Schoenberger				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/4/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberger				22e ADDRESS 16220 Frederick Rd Gaithersburg					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/7/87		23c NAME OF CEMETERY OR CREMATORY Union Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Leesburg, Loudoun, Virginia			
24 FUNERAL DIRECTOR NAME Carl I. Schoenberger ADDRESS 201 Edwards Ferry Rd, N.E. Colonial Funeral Home of Leesburg, Va. 22075				25a DATE REC'D. BY REGISTRAR 10/9/87		25b REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIVER JAMES JUDGE			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 15, 1987		2b HOUR 1:42A M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1911	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MINS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10116 TENBROOK DRIVE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE AGENT	12b KIND OF BUSINESS OR INDUSTRY MUTUAL BEN	
13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 10116 TENBROOK DRIVE 20901	
14 FATHER'S NAME FIRST MIDDLE LAST THOMAS J. JUDGE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE M. RACINE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 020-14-4834	17 INFORMANT ADDRESS MARILYN L. JUDGE/WIFE/SAME AS 13			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malignant melanoma of skin of 5th digit toe</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 month</u> <u>19 month</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 19</u> , 19 <u>87</u> to <u>Oct 15</u> , 19 <u>87</u> that I (we) last saw the deceased alive on <u>Sept 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.)					
22b SIGNATURE <u>Ralph F. Patten</u>		DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/15/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) RALPH F. PATTEN		22e ADDRESS 1407 WOODSIDE PKWY SILVER SPRING, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE OCT19,1987	23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD		
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a DATE REC'D. BY REGISTRAR OCT 22 1987			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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20% COTTON-PIPER

OCT 23 01

070714 NOV -4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 101. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b HOUR					
BARBARA			KANAK			X 10 25 19 87						M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		2d HOUR			
Female		White		Jan. 12, 1933		54 YRS						10 26 19 87		3:05 P M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH					
Penn.				USA								Montgomery County MD					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY					
Silver Spring				10115 McKenney Ave.				Registered Nurse									
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS							
Md.				Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10115 McKenney Avenue							
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Harold Gill						Mabel Allman											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b SOCIAL SECURITY NO.						17 INFORMANT ADDRESS					
N/A						215 34 3267						Cathy Lee Tennyson (Daughter) Same as 13E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
Cirrhosis due to chronic alcoholism																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Charles P. Kokes</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER														DATE SIGNED 10-27-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.														ADDRESS 111 Penn St., Balto., MD 21201			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE							
Cremation				10/28/87		METROPOLITAN CREMATORY				ALEX. VA.							
24 FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.										25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
										NOV 3 1987		<u>Julia Davidson-Randall</u>					

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(VR A15 ME (15))

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WINDMILL BRAND



NOV 3 1948

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (Last, first, or print) Benjamin (NMN) Kasden			2a DATE OF DEATH MONTH DAY YEAR 10-30-87		2b HOUR 2:30AM
3 SEX M	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 2 28 00	6 AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (COUNTRY) Russia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD		
10 CITY OR TOWN OF DEATH Rockville, MD	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MD		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH ? KASDEN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a STREET ADDRESS / ZIP CODE 11548 Brady Hall Lane 878	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR VETERAN'S) 111-12-1189		17 INFORMANT ADDRESS Hospital Maint. UNKNOWN	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Ascending Cholangitis					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Abdominal Aortic Aneurysm. Pleural effusion.					
19a DATE OF OPERATION 9/29/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Multiple Common Bile Duct Stones		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) (this hospital) attended the deceased from 10/29/87 to 10/29/87 that (i) (we) last saw the deceased alive on 10/29/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) did not see the body after death.					
22b SIGNATURE THOMAS G. GARVY II MD		22c DEGREE MD		22d DATE SIGNED 10/31/87	
22e PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. GARVY II MD		22f ADDRESS 11510 Old Georgetown Rd. Rockville, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11-1-87		23c NAME OF CEMETERY OR CREMATORY JUDEAN MEM GDNS	
23d LOCATION CITY OR TOWN COUNTY STATE OLNEY MD.		24 FUNERAL HOME NAME ADDRESS DAN GANSKY-GOLDBERG MEM CHPS INC. 1170 ROCKVILLE PK. ROCKVILLE MD.		25a DATE REC'D BY REGISTRAR NOV 04 1987	
25b REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

WING COMMANDER
 PROTESTANT

WING

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDNA KASNETT				2a DATE OF DEATH MONTH DAY YEAR October 2, 1987			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 12, 1901		2b HOUR 10:22^a AM	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt., Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill of Silver Spring		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Kensington		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Wolf		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Cohen		13e STREET ADDRESS / ZIP CODE 10920 Connecticut Ave. (20895)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 578-44-7802		17 INFORMANT ADDRESS #1301; Rockville, Md. 20852 Dr. Shelton Kasnett; Son; 10500 Rockville Pike,			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 5 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from JULY 19 82 to OCT 2 19 87 that (I) (we) last saw the deceased alive on SEPT 29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE JON M. WISEMAN, M.D.				DEGREE MD		22c DATE SIGNED Oct. 2, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JON M. WISEMAN, M.D.				22e ADDRESS 5410 Connecticut Avenue, N.W., #103; Wash., D.C.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/4/87		23c NAME OF CEMETERY OR CREMATORY Beth Shalom Cong. Cemetery; Capitol Heights; P.G.; Md.		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a DATE REC'D BY REGISTRAR OCT 05 1987		25b REGISTRAR'S SIGNATURE [Signature]	
1170 Rockville Pike; Rockville, Md. 20852							

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29999
26 DATE KNOWN OF DEATH
EST. MONTH DAY YEAR HOUR
27 DATE OF DEATH
EST. MONTH DAY YEAR HOUR
28 DATE PRONOUNCED DEAD
MONTH DAY YEAR HOUR1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Sharlande C. Kenny-With3 SEX F 4 RACE W 5 DATE OF BIRTH
MONTH DAY YEAR 6 AGE (IN YEARS)
LAST BIRTHDAY MONTHS DAYS HOURS MIN
Aug 10 40 YRS7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒

9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD 10 CITY OR TOWN OF DEATH Olney 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.

12a USUAL OCCUPATION (TYPE OR INDUSTRY) Dictaphone Security Operator 12b KIND OF BUSINESS SYSTEMS 13a STATE Md 13b COUNTY Mont 13c CITY OR TOWN Olney

14 FATHER'S NAME FIRST MIDDLE LAST Unobtainable 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unobtainable

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 413 64 3494 17 HOME ADDRESS 2908 Collins Avenue Wheaton, Md. Ted Randolph (Son)

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Dis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last }
(b) Malnutrition
DUE TO, OR AS A CONSEQUENCE OF
(c) Anorexia NervosaPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
None19a DATE OF OPERATION None 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☐ NO ☒21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) M.D. [Signature] MEDICAL EXAMINER DATE SIGNED Oct 17 1987

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers MD ADDRESS 1919 Seminary Rd. S.S.Md.

23a BURIAL, CREMATION, REMOVAL (a) Cremation 23b DATE 10/19/87 23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alex. Va. 23d LOCATION CITY OR TOWN COUNTY STATE

24 FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave., S.S. Md. 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 '84
25M

BP

DHMH - 17
(VR A15 ME (5))

OCT 20 1987

0130 0130



0130 0130

070356 OCT 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE LOUISE LAST Kidwell			2a DATE OF DEATH MONTH DAY YEAR 10-24-87		2b HOUR 4 ²⁵ P.M.
3 SEX Fe	4 RACE CAUC.	5 DATE OF BIRTH MONTH DAY YEAR 10 15 01		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		
10 CITY OR TOWN OF DEATH SILVER SPRING MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARA CARE NURSING HOME		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND		13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2012 HANOVER ST. 20901
14 FATHER'S NAME FIRST GEORGE MIDDLE RIVERS LAST			15 MOTHER'S MAIDEN NAME FIRST MAUD MIDDLE LOUISE LAST SEDGEWICK		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ADDRESS SON RICHARD KIDWELL 424 BRANCH DR. SILVER SPRING, MD. 20901	
18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>diabetes mellitus, chronic atrial fibrillation</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (1) (this hospital) attended the deceased from 19 <u>65</u> to 19 <u>10-24-87</u> that (1) <u>was</u> lost saw the deceased alive on <u>10-22-87</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>did</u> (2) <u>did not</u> view the body after death.					
22a SIGNATURE <u>George F. Sengstack</u>		22b DEGREE MD		22c DATE SIGNED 10-24-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE F. SENGSTACK		22e ADDRESS 9241 COLUMBIA BLVD. SILVER SPRING MD. 20910			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCT. 25, 1987	23c NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY ALEXANDRIA VA.		23d LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS JR. 500 UNIVERSITY BLVD. W.		25a DATE REC'D. BY REGISTRAR OCT 29 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07 OCT 1950

07 OCT 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1a DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CAROLYN

M.

KING

2a DATE OF DEATH

MONTH

DAY

YEAR

10-31-87

2b HOUR

10:15 AM

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR

Jan. 24, 1897

6 AGE (IN YEARS LAST BIRTHDAY)

90

7 UNDER YEAR

MONTH DAY YEAR

HOURS MIN.

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Virginia

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10 CITY OR TOWN OF DEATH

Fairfaxburg

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS OR INDUSTRY

Home

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Rockville

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

5717 Stillwell Rd. 20851

14 FATHER'S NAME

FIRST

MIDDLE

LAST

William

Morefield

15 MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Brownie

Breeding

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17 INFORMANT

ADDRESS

225-22-0787

17 INFORMANT ADDRESS

Marvin E. King (son) same as 13e

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIO PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

CEREBROVASCULAR INSUFFICIENCY

DUE TO, OR AS A CONSEQUENCE OF

(c)

CHRONIC ORGANIC BRAIN SYNDROME

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY SYSTEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

AT HOME ☐ NOT AT HOME ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY

(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 11-22-1982 to 10-31-1987 that (I) (we) last saw the deceased alive on 10/30/1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

MD

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

IRVING MIZUS, MD

22e ADDRESS

5413 CEDAR LANE #206C BETHESDA, MD 20814

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

11/7/87

23c NAME OF CEMETERY OR CREMATORY

Oakwood Cemetery

23d LOCATION

Pulaski, Virginia

STATE

24 FUNERAL DIRECTOR

Tyson Wheeler Funeral Home, Inc.

25a DATE REC'D. BY REGISTRAR

NOV 06 1987

25b REGISTRAR'S SIGNATURE

J. S. Sander-Randall

1331 Rockville Pike, Rockville, Md. 20852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completed. It should be filed with the funeral home. Page 2 should be filed with the funeral home. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

71172 NOV-30

Female
Virginia
White
U.S.A.
Jan. 24, 1897
X

Maryland
Montgomery
Rockville
Brownie
Breeding
52-55-0787
Marvin E. King (son) same as 156
Hennsville
5217 Hennsville Rd. 20851
Home

William



1371 Rockville Lane, Rockville, Md. 20852
Tyrone Wheeler Funeral Home, Inc.
Rockville, Md. 20852

69626 OCT 26 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joan W. King			2a DATE OF DEATH MONTH DAY YEAR 10 19 87		2b HOUR 01:38am
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 10 08 27		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS	IF UNDER 1 YEAR MONTH DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	12b KIND OF BUSINESS OR INDUSTRY EDUCATION	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b COUNTY MONTGOMERY	13c CITY OR TOWN SANDY SPRINGS	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST RICHARD J. WEENACHT			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET I. RATTIGER		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 152-20-9850		17 INFORMANT ADDRESS MARY K. PETERSON 8204 PETE WYLES RD. MIDDLETOWN, Md.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Metastatic vaginal carcinoma</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) this hospital attended the deceased from <u>Oct 18</u> , 19 <u>87</u> , to <u>Oct 19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Oct 19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Joseph M. Rogers</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Rogers		22e ADDRESS Montgomery Gen Hospital, Olney Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-19-1987	23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS 20910 SILVER SPRING, Md.		25a DATE REC'D. BY REGISTRAR OCT 23 1987	25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

000 000 000 000 000

69080 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Willard B. King</u>			2a DATE OF DEATH MONTH DAY YEAR <u>10 14 87</u>		2b HOUR <u>0200</u> M
3 SEX <u>male</u>	4 RACE <u>White</u>	5 DATE OF BIRTH MONTH DAY YEAR <u>04 13 21</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>66</u> YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MINS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD	
10 CITY OR TOWN OF DEATH <u>Rockville</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hosp.</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Crane Operator</u>	12b KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
13a STATE <u>Maryland</u>	13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Gaithersburg</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <u>215 Lee St, Apt 2</u> <u>20877</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Lawrence King</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mabel Buriss</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <u>214-18-8370</u>	17 INFORMANT ADDRESS <u>Peggy Ann White, Mt. Airy, Md. 21771</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatorenal Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Laennec's cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>peptic ulcer with GI bleeding</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bilateral pneumonia, Gangrene foot, malnutrition</u>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>87</u> , to <u>10/13</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <u>S. W. Throw</u>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/14/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. W. Throw</u>		22e ADDRESS <u>#105</u> <u>15225 Shady Grove Rd, Rockville</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b DATE <u>Oct. 16, 1987</u>	23c NAME OF CEMETERY OR CREMATORY <u>Flower Hill Church</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Redland Montgomery Md.</u>	
24 FUNERAL DIRECTOR NAME ADDRESS <u>MURIEL H. BARBER FUNERAL HOME, LAYTONSVILLE MD</u>		25a DATE REC'D BY REGISTRAR <u>OCT 19 1987</u>		25b REGISTRAR'S SIGNATURE <u>J. A. Swinson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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20

067702 OCT-087

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. DECEASED NAME (TYPE OR PRINT) CLAIRE M. Kitchen			2. DATE OF DEATH MONTH DAY YEAR 10/1/87		3. HOUR 0945 AM	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jan. 8, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 85		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Potomac	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Franklin Marsden			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Hill			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-48-2894		17 INFORMANT ADDRESS Meredith E. Hill Rt 2 Box 99-114 Inwood, West Virginia		
18 CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CLINICAL VENTRICULAR ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CLINICAL MASSIVE C.V.A. DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 31 July 1987 to Oct 1 1987 that (I) <input checked="" type="checkbox"/> saw the deceased alive on Sept 25 1987 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.						
22b SIGNATURE Thomas E. Dooly, M.D.		22c DATE SIGNED Oct 1, 1987		22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooly, M.D.		
22e ADDRESS 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 5, 1987		23c NAME OF CEMETERY OR CREMATORY Potomac United Meth. Church Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland		23e DATE RECEIVED BY REGISTRAR OCT 05 1987				
24 FUNERAL DIRECTOR Robert A. Humphrey		24b ADDRESS Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814		24c REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

187505 001-001

187505 001-001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ANNA		KOVNER		10-7-87		450 A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		
Female	White	March 15 - 1898		89	YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Austro-Poland	United States			MONTGOMERY MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Hebrew Home of Greater Washington			Homemaker		Home	

13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery	Rockville		6121 Montrose Rd. 20852	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16. ADDRESS		
Soloman Kornblau		Sarah Hanft		1908 Franwall SS., Md. 20902		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT				
No	N/A	082 07 2119 Daughter: Alice Kovner Bruckner				

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> . DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro Vascular Accident</u> . DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Atherosclerosis</u> .		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		1 day
		years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)	20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21a. INJURY OCCURRED (HOMER <input type="checkbox"/> NOT HOMER <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21c. LOCATION (STREET CITY OR TOWN COUNTY STATE)	
22a. I certify that XX this hospital attended the deceased from <u>Oct 27</u> 19 <u>82</u> to <u>Oct 7</u> 19 <u>87</u> XXXX and that in my <u>my</u> (my) my <u>my</u> opinion death occurred on the date and hour and from the causes stated above. (If not, I did not see the body after death.)			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<u>Loretto S. Albiof, MD</u>			10-7-87
22d. PHYSICIAN'S NAME (TYPE OF PRINT)		22e. ADDRESS	
LORETO S. ALBIOF		6121 MONTROSE RD.	

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN COUNTY STATE)
Burial	Oct. 11, 1987	Star of David Mem. Pk.,	Miami, Florida
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ives-Pearson Funeral Homes Falls Church, Va. 22046		OCT 09 1987	<u>Davidson-Randall</u>

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69345 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA KRASNOGOR			2a DATE OF DEATH MONTH DAY YEAR 10/19/87			2b HOUR 8:54 PM				
3 SEX FEMALE		4 RACE CAUCASION		5 DATE OF BIRTH MONTH DAY YEAR 07/10/03		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7 UNDER 1 YEAR MONTHS DAYS 10 10		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED-SEAMSTRESS		12b KIND OF BUSINESS OR INDUSTRY LADIES WEAR		
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN ROCKVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6111 MONTROSE RD./20852	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Krempel			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Licht			16a DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b SOCIAL SECURITY NO. 104-18-5424			17 INFORMANT Eugene Goodman; Son, 8105 Horseshoe Lane; Potomac, Md. 20854							
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE MYOCARDIAL ISCHEMIA										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I HYPERTENSION										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 9-25 , 19 87 to 10-19 , 19 87 that (I) (we) last saw the deceased alive on 10-19-87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Kamalin G. Deslyand MD						DEGREE MD		22c DATE SIGNED 10-20-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) KAMALINGEV. DEZHANAE						22e ADDRESS 6001 LUX LANE Rockville Md 20852				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/21/87		23c NAME OF CEMETERY OR CREMATORY King David Mem. Gardens; Falls Church; Fairfax; Va.		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS						25a DATE REC'D. BY REGISTRAR OCT 21 1987				
1170 Rockville Pike; Rockville, Md. 20852						25b REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

Referred by Medical Examiner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon and page 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "AT WORK" it is mandatory to report any injury or other traumatic event. Medical examination must be notified in writing.

BP

168312 OCT 25 83

10-25-83

OCT 25 1983

68312 OCT 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ELIZABETH Krantz KUEST		2a DATE OF DEATH MONTH DAY YEAR October 3 1987		2b HOUR 10³⁵ a.m.
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR May 7, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 75
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Germantown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Frank Krantz		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Remissong		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 343-09-0808		17 INFORMANT Son Martin F. Kuest 10107 Huntley Avenue Silver Spring, MD. 20902

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Cerebral Vascular accident**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION None	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) the hospital attended the deceased from June 15, 1987 to October 03, 1987 that (2) I saw the deceased alive on October 02, 1987 and that in (my) opinion death occurred on the date and hour and from the causes stated above; (3) I did not view the body after death.			
22b SIGNATURE M. D.		22c DATE SIGNED Oct 3, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Talley F. Witte		22e ADDRESS 9715 Medical Center Drive Rockville, MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Oct. 4, 1987	23c NAME OF CEMETERY OR CREMATORY Montgomery Crematorium	23d LOCATION CITY OR TOWN COUNTY STATE Bethesda Montgomery MD.
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, MD. 20850		25a DATE REC'D BY REGISTRAR OCT 09 1987	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

070087 OCT 29 1987

2a DECEASED NAME (PRINT)			2b DATE OF DEATH		2c HOUR	
WILLIAM GEORGE LAGOS			OCTOBER 23 1987		4:17 AM	
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JANUARY 2 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTH DAY HOUR MINUTE
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY U.S. NAVY	

13a STATE MARYLAND		13b COUNTY MONTGOMERY	13c CITY OR TOWN ROCKVILLE	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 11801 ROCKVILLE PIKE 20852	
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE WILLIAM LAGOS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEO ZEPPUS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 025-14-162		17 INFORMANT ADDRESS GEORGE LAGOS, 11801 ROCKVILLE PIKE, ROCKVILLE, MD		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE AND ISCHEMIC</u>	
DUE TO, OR AS A CONSEQUENCE OF		(c) <u>MITRAL VALVE DISEASE</u>	
DUE TO, OR AS A CONSEQUENCE OF		(d) <u>HEPATIC RENAL FAILURE AND SEPSIS</u>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from OCTOBER 18 19 87 to OCTOBER 23 19 87 that (I) (we) last saw the deceased alive on OCTOBER 23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <u>Edward L. Woods</u> MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>23 OCT 87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. L. WOODS, CDR, MC, USN</u>		22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (CITY OR TOWN)
Burial	10/26/87	Parklawn Cemetery	Rockville Mont. Md.
24 FUNERAL DIRECTOR <u>Hines/Rinaldi</u> 11800 New Hamp. Ave. S.S. Md.		25a DATE REC'D BY REGISTRAR <u>OCT 27 1987</u>	25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

070000 OCT 22 21

DIAGON CIBED



CH. V. B. & S. B.
W. B. B.

068479 OCT 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 3 0 0 9

1 DECEASED NAME (TYPE OR PRINT) <u>Jerome B Laird</u>				2a DATE OF DEATH MONTH <u>10</u> DAY <u>5</u> YEAR <u>87</u>		2b HOUR <u>11 A M</u>	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH <u>4</u> DAY <u>26</u> YEAR <u>34</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>53</u> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Washington</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD	
10 CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Management</u>	
12b KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		13a STATE <u>Md.</u> 13b COUNTY <u>PG</u> 13c CITY OR TOWN <u>Adelphi</u> 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
14 FATHER'S NAME FIRST <u>DeEstine</u> MIDDLE <u>Ralph</u> LAST <u>Laird</u>				15 MOTHER'S MAIDEN NAME FIRST <u>Nelly</u> MIDDLE <u>Elizabeth</u> LAST <u>Lippert</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <u>Army</u>		17 INFORMANT <u>5563 E. Evergreen Blvd.</u> <u>Nelly Laird (Mother) Vancouver, Washington</u>			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Candia - Pulm Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Toxoplasmosis - brain</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 <u>a.c.g. Immune Def Syndrome</u> <u>Left hemiparesis</u>							
19a DATE OF OPERATION <u>Feb 23-87</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Craniotomy - mass - Glioma</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from <u>Nov 10-3</u> 19 <u>87</u> to <u>10-5</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>10-3</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (1) did (1) did not view the body after death							
22b SIGNATURE <u>R.H. Sandstrom MD</u>				DEGREE <u>MD</u>		22c DATE SIGNED <u>10-5-87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>R.H. Sandstrom MD</u>				22e ADDRESS <u>7701 Carroll Ave Takoma Park, Md 20912</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>10/6/87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Alex. Va.</u>	
24 FUNERAL DIRECTOR NAME <u>Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.</u>				25a DATE REC'D. BY REGISTRAR <u>OCT 13 1987</u>		25b REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified or once.

069171 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30010

REG NO

1 DECEASED NAME (TYPE OR PRINT) ANTONIO F. LANCASTER			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 11, 1987		2b HOUR 9:00 P.M.	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b KIND OF BUSINESS OR INDUSTRY US Gov't.
13a STATE MD			13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase	
14 FATHER'S NAME FIRST MIDDLE LAST Eustace John Lancaster			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Philomena Eopolucci			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-32-4037		17 INFORMANT ADDRESS Florence S. Mazzocchi, Same address as #13.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) attended attended the deceased from MAY 19 87 to 11 OCT 19 87 that (I) last saw the deceased alive on 28 SEPT 19 87 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If not used, do not view the body after death.)						
22b SIGNATURE <i>Walter E. Goosz</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOSZ, M.D.				22e ADDRESS 2309 SHOREFIELD RD., WHEATON, MD 20906		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/13/87		23c NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA
24 FUNERAL DIRECTOR (NAME) JOSEPH GAWLER'S SONS, INC. 5130 WISC. AVE., N.W., WASH., D.C. 20016				25a DATE REC'D. BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

069171 OCT 20 67

9:00 P.M.

OCTOBER 17, 1967

LABORATORY

ANTHROPOLOGY

CHICAGO

MALE

COLLIERWOOD HUNTING CENTER

HOUSTON

25% COLLECTED - FIBER

④

DOWN

10/17/67

3500 BRICKFIELD RD., WHEATON, MD 20806

WALTER E. GORDON, M.D.

10/13/67

2100 WASH. AVE., N.W., WASH., D.C. 20036
JOSEPH GAVIN'S BOOK, INC.

OCT 18 1967

U.S. AIR FORCE

069885 OCT 27 1987

item 13d 13a film G633

1- STATE
REGISTRAR

11-2-87 I.J.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Raymond A. Lang			2a DATE OF DEATH MONTH DAY YEAR 10 17 87			2b HOUR 2022 ^M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR October 3, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cartographer		12b KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Alfred R. Lang			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie C. Duhs			13e STREET ADDRESS / ZIP CODE 13305 Southwood Drive 20850			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Ruby Franks Lang (Wife) 13305 Southwood Drive Rockville, Maryland 20850					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Candida esophagitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immunosuppression for asymptomatic vesicular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>weeks</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Congestive heart failure, progressive aortic stenosis, atherosclerotic heart disease</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from <u>10/4</u> , 19 <u>87</u> to <u>10/17</u> , 19 <u>87</u> that (I/we) last saw the deceased alive on <u>10/17</u> , 19 <u>87</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)									
22b SIGNATURE <u>Byrl D. Johnson</u>				DEGREE <u>MD</u>				22c DATE SIGNED <u>10/18/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>BYRL D. JOHNSON</u>				22e ADDRESS <u>911 N. Russell Ave. Gaithersburg, Md 20879</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE <u>October 21, 1987</u>		23c NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem.</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Darnestown Montgomery, Maryland</u>			
24 FUNERAL DIRECTOR Name <u>Robt. A. Pumphrey Funeral Home-Rockville, Inc.</u>				25a DATE REC'D BY REGISTRAR <u>OCT 26 1987</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			
300 W. Montgomery Ave., Rockville, Md. 20850									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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067703 OCT-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		9:30		a. M.	
Cheslye Long Larrimer								October 01, 1987													
3 SEX		4 RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Female		White		July 22, 1896								91 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Missouri		United States						Montgomery		Montgomery General Hospital		Homemaker		Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE													
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3683 Leisure World Boulevard													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Henry		T. Long		Emma																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT																	
no		578-54-1955		C. Ann Preston																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.)		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		cardio respiratory arrest		Hypotension from				Inappropriate ADH Secretion				Days									
												Weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
		P.M.		19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION																	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> ALL WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (i) (this hospital) attended the deceased from <u>Dec 1987</u> to <u>1 Oct 1987</u> that (i) <u>was</u> last saw the deceased alive on <u>1 Oct 1987</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED																	
Dr. Marian Chung / Y. Belaval		M.D.		1 Oct 87																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																			
Marian Chung, M.D.		3701 Rossmore Boulevard																			
		Silver Spring, MD 20906																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION															
Cremation		Oct. 3, 1987		Montgomery Crematorium, Inc.		Bethesda, Maryland															
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE																	
Robert A. Pumphrey		OCT 05 1987		Davidson-Rodell																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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001103 OCT-2015

069824 OCT 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lydia Jane Lawson			2a. DATE OF DEATH MONTH DAY YEAR Oct. 18, 1987		2b. HOUR 11:45P_M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 14, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS IF UNDER 24 HRS HOURS MINUTES
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE ---		13b. COUNTY ---	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert James Buxton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clelia Amelia Werner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 396-10-4341		17. INFORMANT ADDRESS John B. Lawson, Same address as #13.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cerebral thrombosesAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 years**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

b)

DUE TO, OR AS A CONSEQUENCE OF

c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) the hospital attended the deceased from 1987 to Oct 18 19 87 that (I) (we) last saw the deceased alive on Oct 18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated Wesley M. Oler DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wesley M. Oler		22e. ADDRESS 3301 New Mexico Ave, NW, Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/20/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		23e. DATE REC'D BY REGISTRAR (25) REGISTRAR'S SIGNATURE OCT 26 1987	

24. FUNERAL DIRECTOR **Joseph Gawler's Sons, Inc.****5130 Wisconsin Ave, NW, Washington, D.C. 20016**

25a. DATE REC'D BY REGISTRAR (25) REGISTRAR'S SIGNATURE

OCT 26 1987

25b. REGISTRAR'S SIGNATURE

John B. Lawson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial transit permit. For all other purposes, remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, it is subject to any injury or other traumatic event, the medical examiner may be notified at once.

06854 021 57 01

069818 OCT 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30014

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

Richard

P

MIDDLE P LAST Lawton

LAWTON

2a DATE KNOWN OF ESTI. DEATH MATED ☒ MONTH 12 DAY 12 YEAR 1987 HOUR 07¹⁵ M

3 SEX
Male

4 RACE
White

5 DATE OF BIRTH
MONTH 05 DAY 23 YEAR 32

6 AGE (IN YEARS)
55 YRS

IF UNDER 1 YR.
MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN

2c DATE PRONOUNCED DEAD MONTH 10 DAY 12 YEAR 1987 HOUR 07¹⁵ M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DC

7b CITIZEN OF WHAT COUNTRY?
U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD

10 CITY OR TOWN OF DEATH
BETHESDA

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Personnel

12b KIND OF BUSINESS OR INDUSTRY
Human Resources

13a STATE
MD

13b COUNTY
Mont.

13c CITY OR TOWN
Bethesda

13d INSIDE CITY LIMITS?
YES ☒ NO ☐

13e STREET ADDRESS
5109 WESTBARK AVE

14 FATHER'S NAME
FIRST Frederick

MIDDLE

LAST Lawton

15 MOTHER'S MAIDEN NAME
FIRST Cecelia

MIDDLE

LAST Walsh

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes

1953-1957

16b SOCIAL SECURITY NO.
579-40-7544

17 INFORMANT ADDRESS
Mary Catherine Lawton Same as # 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY

888 IMMEDIATE CAUSE (a) HEPATIC FAILURE

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause last

(b) CIRRHOSIS OF LIVER

DUE TO, OR AS A CONSEQUENCE OF

(c) ETHANOLISM

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WEEKS

YRS

IN DEC

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

CEREBRAL CONTUSION SUBARACHNOID HEMORRHAGE

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?
YES ☐ NO ☒

21a EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
1500 P.M. 09 18 1987

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
FELL ON SIDEWALK

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)
STREET

21f LOCATION
STREET CITY OR TOWN COUNTY STATE
5400 WESTBARK AVE BETHESDA MONTGOMERY MD

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

EXAMINER'S SIGNATURE
Francis C. Mayle

TITLE (SPECIFY)
DEPT

MEDICAL EXAMINER

DATE SIGNED
10/13/87

EXAMINER'S NAME
(TYPE OR PRINT)

FRANCIS C. MAYLE

ADDRESS
8200 Wisconsin Ave Bethesda MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b DATE
10/15/87

23c NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem.

23d LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, MD

24 FUNERAL DIRECTOR
NAME

Joseph Gawler's Sons, Inc.

5130 WI Ave. NW Wash., DC 20016

25a DATE REC'D. BY REGISTRAR
OCT 26 1987

25b REGISTRAR'S SIGNATURE
Julia Dawson-Ruback

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHM-17
(VR A15 ME (5))

000018 012717

Richard
Houston

White

U.S.A.

IN

Personnel

x

Bedford

North

ND

Bedford

Bedford

Bedford

Bedford

1955-1957 1955-1957 1955-1957 1955-1957



10/15/57 Date of Heaven Rem.
Silver Spring, MD
Joseph David's Sons, Inc.
2150 W. Ave. N. Wash., D.C. 20016

30
070487 NOV-21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Eva H Leahy			2a DATE OF DEATH MONTH DAY YEAR 10/23/87		2b HOURS MIN 4:55 AM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1914		6 AGE (IN YEARS LAST BIRTHDAY) YRS 73	
7a BIRTHPLACE (COUNTRY) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15145 Vantage Hill Rd		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY HOME
13a STATE md		13b COUNTY Mont.	13c CITY OR TOWN S.S.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST BISHOP M. HARDY			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA SMITH		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 577-32-3648		17 INFORMANT M. CARY LEAHEY ADDRESS 410 RIVERSIDE DR #33 NEW YORK, NEW YORK	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Right Sided Heart Failure					5 years
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Hypertension					6 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Atherosclerosis, Osteoporosis, Vertebral Body Compression Fracture.					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from June 84 to OCT 22 87 , that (I) (we) last saw the deceased alive on OCT 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Oliver J Lawless MD				22c DATE SIGNED 10/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) OLIVER J LAWLESS MD				22e ADDRESS 363701 Rossmore Blvd S.S. Spring 20906	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCT. 26, 1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG CO. MARYLAND		23e DATE REC'D BY REGISTRAR OCT 30 1987			
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME SILVER SPRING, MARYLAND		25 REGISTRAR'S SIGNATURE Julia Davidson-Budner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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068748 OCT 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank J. LaBon			2a. DATE OF DEATH MONTH DAY YEAR 10 11 1987			2b. HOUR 11:45 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 10 1910		6. AGE (IN YEARS, LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home - same address as #13				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b. KIND OF BUSINESS OR INDUSTRY Union	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9931 Ridgeline Dr., 20879	
14. FATHER'S NAME FIRST MIDDLE LAST John Michael Labansky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Berta Junge						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Mar. 19, 1942		17. INFORMANT Helen B. LaBon, Gaithersburg, Md. 20879					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>10/11/87</u> , 19 <u>87</u> , to <u>10/11/87</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>10/11/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If last (1) did not view the body after death.)									
22b. SIGNATURE <u>John Weiner</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Weiner</u>						22e. ADDRESS <u>4501 Rockville Rd Rockville Md 20852</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.		
24. FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md. 20879						25. DATE REC'D. BY REGISTRAR OCT 15 1987			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove number plates. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

BP

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OCT 15 1967

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FOR
STATE
REGISTRATIONSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST MEYER LEDER			MONTH DAY YEAR 10/27/87		6A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. BIRTHPLACE
Male	White	MONTH DAY YEAR Sept. 20, 1907		YRS 80		COUNTRY Poland
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Poland	U.S.A.			MONTGOMERY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Hebrew Home of Greater Washington		Product Manager		Garment Industry	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
Maryland		Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		15e. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST WOLF LEDER		FIRST MIDDLE LAST BLUMA KORETZ		6121 Montrose Road (20852)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
YES		WWII 062-10-6868		McLean, Va. 22102		
18. CAUSE OF DEATH		18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY		PART I. DEATH WAS CAUSED BY				
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)				
RESPIRATORY FAILURE		RESPIRATORY FAILURE				1 MONTH
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF				
(b) CHRONIC OBSTRUCTIVE LUNG DISEASE		(b) CHRONIC OBSTRUCTIVE LUNG DISEASE				MANY YEARS
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF				
(c) CIGARETTE SMOKING		(c) CIGARETTE SMOKING				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
SQUAMOUS CELL CARCINOMA OF THE LUNG						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		
				ENTER NATURE OF INJURY IN ITEM OR PART 1 OR PART 2		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		
				STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 8/16/87 to 8/3/87 to 10/27/87 19 87 , that (I) (we) last saw the deceased alive on 10/27/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		22c. DATE SIGNED
D. D. PATEL		M.D.		X		10/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
D. D. PATEL M.D.		6121 MONTROSE RD, ROCKVILLE, MD 20852				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		10/29/87	Cedar Park Cemetery		Westwood, New Jersey	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		OCT 30 1987		Julia Gordon-Randall		
1170 Rockville Pike; Rockville, Md. 20852						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the funeral or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATESTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) ROSE MARY J. LENARD		2a DATE OF DEATH MONTH DAY YEAR OCT 17 1987		2b HOUR 4-10 PM	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR June 20, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 10220 Grant Avenue 20910	
14 FATHER'S NAME FIRST MIDDLE LAST Edwin Finckel		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nell O'Callahan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 067-24-6499		17 INFORMANT Daughter Chari Stoesser ADDRESS 6111 Cedar Wood Drive Columbia, Maryland 21044	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>Oct. 8</i> 1987 to <i>Oct 17</i> 1987 that (I) <i>we</i> last saw the deceased alive on <i>Oct 17</i> 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Raymond Bradshaw, MD</i>		DEGREE		22c DATE SIGNED <i>Oct 17, 1987</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Raymond Bradshaw</i>		22e ADDRESS <i>345 University Blvd., W Silver Spring, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 17, 1987	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d LOCATION CITY OR TOWN COUNTY STATE Virginia
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a DATE REC'D. BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <i>William Henderson-Randall</i>	
500 University Blvd., W. Silver Spring, Md. 20901					

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7 84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I" (injury), item 18 should be marked "I" (injury), or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

064-48 234 230

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the state paper pages, hand 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of the event.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN
		CECELIA TOLSTOI LEVEY					10-8-1987				2	36
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR		
FEMALE		WHITE		7-19-1905		82 YRS		MONTHS		DAYS		MIN
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
WASH. D.C.		U. S. A.				MONTGOMERY COUNTY						MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
SILVER SPRING		HOLY CROSS HOSPITAL		MERCHANT		CLOTHING						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MARYLAND		MONTGOMERY		Silver Spr.				10907 Wheeler Dr. 20901				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME										
DAVID TOLSTOI		ESTHER NIMETZ										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT								
NO		578-48-2218		ESTHER LINCHUCK, SILVER SPRING, MARYLAND								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute GI Bleed</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Celiac Sprue Duodenal ulcer</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3 OR PART 4)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from <u>9/28/87</u> 19 <u>87</u> to <u>10/8</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10/7</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (did) not view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
Shelley Luby-Gottheim M.D.						10/8/87						
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS										
Shelley Luby-Gottheim M.D.		1106 Spring St. Silver Spring Md. 20910										
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN						
BURIAL		10/11/1987		KING DAVID MEMORIAL GARDEN		FALLS CHURCH, VIRGINIA						
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		OCT 15 1987		A. Hurdman-Henderson								
232 CARROLL STREET, N. W., WASHINGTON, D. C.												

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN LEVIN			2a DATE OF DEATH MONTH DAY YEAR 10 28 87			2b HOUR 530 P.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 1 24 20		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF BUSINESS, SERVICE OR WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY OWN HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND				13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB SHAFER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE YOUNGERMAN		13e STREET ADDRESS / ZIP CODE 1131 UNIVERSITY BOULEVARD, WEST 20902			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 150-07-6696		17 INFORMANT PETER LEVIN		1131 UNIVERSITY BOULEVARD, WEST SILVER SPRING, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 7/2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Gastritis with GI bleeding DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 weeks									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) malabsorption, possibly due to celiac sprue									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 10/7 19 87 to 10/28 19 87 that (2) (we) last saw the deceased alive on 10/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (3) (we) (did) (did not) view the body after death.									
22b SIGNATURE Carmella Cole				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Carmella Cole, MD				22e ADDRESS 250 Hungerford Drive Suite 14 Rockville, MD 20850					
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 10/30/1987		23c NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d LOCATION ADELPHI, PR. GEORGES, MARYLAND			
24 DONOR DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a DATE REC'D. BY REGISTRAR NOV 02 1987		25b REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send cotton papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

June 27 1967

1967

June

1. The first part of the report deals with the general situation in the country. It is a very interesting and informative account of the current state of affairs. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

2. The second part of the report deals with the economic situation. It is a very detailed and thorough account of the current state of the economy. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

3. The third part of the report deals with the social situation. It is a very detailed and thorough account of the current state of society. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

4. The fourth part of the report deals with the political situation. It is a very detailed and thorough account of the current state of politics. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

5. The fifth part of the report deals with the cultural situation. It is a very detailed and thorough account of the current state of culture. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

6. The sixth part of the report deals with the environmental situation. It is a very detailed and thorough account of the current state of the environment. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

7. The seventh part of the report deals with the international situation. It is a very detailed and thorough account of the current state of international relations. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

8. The eighth part of the report deals with the future of the country. It is a very detailed and thorough account of the current state of the future. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

9. The ninth part of the report deals with the conclusion. It is a very detailed and thorough account of the current state of the conclusion. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

10. The tenth part of the report deals with the appendix. It is a very detailed and thorough account of the current state of the appendix. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country and its people.

069504 OCT 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

70 DATE OF DEATH MONTH DAY YEAR 10 13 87 2b HOUR 8:40 AM

1 DECEASED NAME (TYPE OR PRINT)

FIRST

MIDDLE

LAST

Myer

Levin

3 SEX MALE

4 RACE WHITE

5 DATE OF BIRTH JUNE 4, 1914

6 AGE (IN YEARS LAST BIRTHDAY) 73

7b UNDER 5 YEAR MONTHS DAYS

8 UNDER 24 HRS HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN) WASHINGTON DC

7b CITIZEN OF WHAT COUNTRY? U S A

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.

10 CITY OR TOWN OF DEATH BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (SUBURBAN HOSPITAL)

12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) MERCHANT

12b KIND OF BUSINESS OR INDUSTRY DRUGGIST

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE MARYLAND

13b COUNTY MONTGOMERY

13c CITY OR TOWN BETHESDA

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS 8704 EWING DRIVE

20817

14 FATHER'S NAME NATHAN

MIDDLE

LEVIN

15 MOTHER'S MAIDEN NAME MAY

FIRST

SHKLAR

16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES ☒ (OR UNKNOWN) ☐ WW II

16b SOCIAL SECURITY NO. 578-46-5822

17 INFORMANT ADDRESS VIVIAN N. LEVIN, 8704 EWING DRIVE BETHESDA, MARYLAND

18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiogenic Shock

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

30 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Myocardial Infarction

1-2 Hours

DUE TO, OR AS A CONSEQUENCE OF

(c) Coronary artery Disease

Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.)

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHERE ☐ AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10/13, 1987, to 10/13, 1987, that (I) (we) last saw the deceased alive on 10/13, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/13/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Robert Blee MD

22e ADDRESS

5454 Wisconsin Ave Chevy Chase

23a BURIAL, CREMATION, REMOVAL BURIAL

23b DATE

10/14/1987

23c NAME OF CEMETERY OR CREMATORY

NATIONAL MEMORIAL PARK

23d LOCATION

FALLS CHURCH

COUNTY

STATE

VIRGINIA

24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W. WASHINGTON, D. C.

25 DATE REC'D BY REGISTRAR OCT 19 1987

25b REGISTRAR'S SIGNATURE Julia Benson-Randall

Case Released by Coroner Dr. Tauber
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove calligraphic signatures and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100-100

7

100-100-100

100-100-100

100-100-100

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100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME FIRST MIDDLE LAST LEO LEVITT			2a DATE OF DEATH MONTH DAY YEAR 10 25 87		2b HOUR 2.45 A M
3 SEX MALE	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 8 9 19	6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR IF UNDER 1 MONTH
7a BIRTHPLACE New York	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASH		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b KIND OF BUSINESS OR INDUSTRY Private
13a USUAL RESIDENCE STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6121 Montrose Rd. 20852	
14 FATHER'S NAME FIRST MIDDLE LAST Jacob Levitt		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. 560 28 4918	17 INFORMANT ADDRESS Edith B. Kaye 2700 Q. St., NW, Wash., D.C.		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>End Stage Parkinson's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Diabetes Mellitus</u>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) the deceased attended the deceased from <u>10-9-86</u> to <u>10-25-87</u> that (ii) the deceased saw the deceased alive on <u>10-25-1987</u> , and that in (my) <u>XX</u> opinion death occurred on the date and hour and from the causes stated above; (i) <u>XX</u> (ii) <u>XX</u> view the body after death.			
22b SIGNATURE <u>Merlyn Vemury MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>10/25/87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>MERLYN VEMURY MD</u>		22e ADDRESS <u>HEBREW HOME OF GREATER WASH</u> <u>6121 MONTROSE RD, ROCKVILLE MARYLAND 20852</u>	
23a BURIAL, CREMATION, REMOVAL Cremation	23b DATE Oct. 27, 1987	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d LOCATION City or Town State Alexandria, Va.
24 FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va. 22046		25a DATE REC'D. BY REGISTRAR OCT 28 1987	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

070171 OCT 29 1987

30022

10 OCT 20 01

10 OCT 20 01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN THE CERTIFICATE TO THE MEDICAL EXAMINER WITHIN 72 HOURS AFTER DEATH. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84 BP _____
25M
DHMH 17
(VR A15 ME (5))

000000 0012701

000000 0012701

ST. JOHN

ST. JOHN



071288 NOV 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30024
REG NO

1 DECEASED NAME (TYPE OR PRINT) IRVING LIBERMAN		7a DATE KNOWN OF DEATH ESTIMATED Oct 29 1987		7b HOUR 12 AM
3 SEX MALE	4 RACE WHITE	5a BIRTH DATE MARCH 1 1920	5b AGE 67 YRS.	6 IF UNDER 1 YR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
7a BIRTHPLACE ILLINOIS	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Sil. Spg	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH ESTABLISHMENT, GIVE STREET ADDRESS) Holy Cross Hosp	12a USUAL OCCUPATION (TYPE OF WORK) LAWYER	12b KIND OF BUSINESS GOVERNMENT CONSULTANT	
13a MARYLAND, 13b COUNTY Mont.		13c CITY OR TOWN Sil Spg	13d INSIDE CITY LIMITS? XX YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11609 Lebaron Ter
14 FATHER'S NAME DAVE LIBERMAN		15 MOTHER'S MAIDEN NAME SEMA STEINBERG		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 322-12-0821		17 INFORMANT ESTHER LIBERMAN, 11609 LEBARON TERRACE SILVER SPRING, MARYLAND

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Chronic Myocardial Dis. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **None**

19a DATE OF OPERATION None	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE John S. Rogers	TITLE (SPECIFY) M.D.
EXAMINER'S NAME (TYPE OR PRINT) DR. JOHN S. ROGERS, M. D.	DATE SIGNED Oct 29, 1987
ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MARYLAND	

23a BURIAL, CREMATION, REMOVAL BURIAL	23b DATE 10/30/1987	23c NATIONAL CEMETERY CAPITOL CEMETERY	23d CITY PRINCE GEORGES	23e STATE MARYLAND
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		25a DATE REC'D BY REGISTRAR NOV 16 1987		
24b ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25b REGISTRAR'S SIGNATURE Richard Handell		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXAMINED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE USED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

5151 1001 1001



202 COTTON 202

Handwritten text, possibly a signature or date, written vertically along the right side of the page.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Shook-Kun Yip Ling			2a DATE OF DEATH MONTH DAY YEAR October 29 1987		2b HOUR 2:30 AM
3 SEX Female	4 RACE Chinese	5 DATE OF BIRTH MONTH DAY YEAR March 18, 1903	6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) China	7b CITIZEN OF WHAT COUNTRY? China	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 9307 Fernwood Road 20817	
14 FATHER'S NAME FIRST MIDDLE LAST Jen-Chu Yip		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liang-Sin Ho			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No		16b SOCIAL SECURITY NO. 217-74-7571	17 INFORMANT ADDRESS Kwok-Chi Gertrude Cheng same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CIRRHOSIS AND PORTAL HYPERTENSION - VERY POOR NUTRITIONAL STATE</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9-15-87</u> , 19 <u>87</u> , to <u>10-29</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10-28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death					
22b SIGNATURE <u>J. Benjamin Untiveros, MD</u>		DEGREE		22c DATE SIGNED 10-29-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. BENJAMIN UNTIVEROS, MD</u>		22e ADDRESS <u>16220 FREDERICK RD #427 GAITHERSBURG, MD 20877</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 31, 1987	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. Ave. Bethesda, Maryland 20814		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <u>John F. [Signature]</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

70576 NOV-3-87
070576

DEPT. OF JUSTICE
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible. It appears to be a memorandum or letter containing several paragraphs of text, possibly discussing a case or administrative matter. The text is mirrored across the page, suggesting it may be a scan of a document with bleed-through or a very poor quality scan.]

070534 NOV-20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30020

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH XX MONTH DAY YEAR		2b HOUR	
George		Douglas		Linville				10 24 19 87		M	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD MONTH DAY YEAR		2d HOUR
Male	White	Dec. 20 37		49 YRS					10 24 19 87		1:25 P
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA						Montgomery County MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Rockville		2511 Baltimore Road				Budget Analyst		A.D.A.M.H.A.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
Maryland		Montgomery		Rockville				2511 Baltimore Road, 20853			
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Gordon Linville						Eliza Hager					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
Yes		Vietnam		233-54-5596 Gordon Linville, 1515 Paul Russel Road							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Dennis F. Smyth M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto.MD.
DATE SIGNED 10/25/87

23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Cremation		10/29/87		Security Process Crem.		Catonsville Baltimore Md.	
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229				OCT 29 1987		Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM MW 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30027

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card staples. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) EILEEN ELIZABETH LOVEJOY			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 18 1987			2b. HOUR 7:30 A.M.					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 10 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9605 COTTRELL TERRACE 20903		
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY STEINER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH TRIEBSCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 167-26-0702		17. INFORMANT (Husband) ADDRESS WILLIAM LOVEJOY, 9605 COTTRELL TERRACE, SILVER SPRING, MD 20903							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 (a))					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 13</u> 19 <u>87</u> to <u>OCTOBER 18</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 18</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward P. Fox						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 19 Oct. 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial			23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Carnegie, Pa.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp Ave. S.S. Md						25a. DATE REC'D. BY REGISTRAR OCT 20 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

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W. B. D. W. D.

OCT 30 1950

070729 NOV-1 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE LOVETT			2a. DATE OF DEATH MONTH DAY YEAR October 29, 1987		2b. HOUR 9:30p. M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 10, 1913		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5225 Pooks Hill Rd., #823 South		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		
14. FATHER'S NAME FIRST MIDDLE LAST Morris Roth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Itzkowitz		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-07-9124		17. INFORMANT ADDRESS Bethesda, Md. 20817 Ronald Cohen; Son-in-Law; 6500 Rockspring Dr.;		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca Breast c metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 3-1 19 74 to 10-29 19 87 that (1) (we) last saw the deceased alive on 10-29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death						
22b. SIGNATURE Bernard H. Ostrow				22c. DATE SIGNED 10-30-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD H. OSTROW				22e. ADDRESS 5225 Pooks Hill Rd Bethesda, MD 20817		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/87		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn., Falls Church, Fairfax; Va.		
23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, MD 20817		23e. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn., Falls Church, Fairfax; Va.		23f. LOCATION CITY OR TOWN COUNTY STATE Bethesda, MD 20817		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR NOV 03 1987		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and approved in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1950

070715 NOV -4-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) YUN C. LU			2a. DATE OF DEATH MONTH DAY YEAR 10 26 87		2b. HOUR 11:28 A.M.		
3. SEX FEMALE		4. RACE Chinese		5. DATE OF BIRTH MONTH DAY YEAR 8 18 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sung Ong Chung		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lee		13e. STREET ADDRESS / ZIP CODE 13201 ARCTIC AVE. 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 462-41-7860		17. INFORMANT 11403 Empire Lane Rockville, Md. Hollington Lu (Son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min one week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>chronic renal failure due to polycystic kidney disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 1982</u> to <u>October 1987</u> that (2) we last saw the deceased alive on <u>Oct 26 1987</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)							
22b. SIGNATURE Mark Rosen		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen		22e. ADDRESS Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/30/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Va.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md				25a. DATE REC'D BY REGISTRAR NOV 3 1987		25b. REGISTRAR'S SIGNATURE T. Anderson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME (PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Leon				Lubel	Oct. 18, 1987				8 ⁰⁰ P M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE	(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male	White		Aug. 4, 1914		73	YRS		MONTH DAY HOUR MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Conn.	U.S.A.				Montgomery MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Chevy Chase	4701 Willard Avenue		Pres. & CEO.		Tire Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
MD		Montgomery	Chevy Chase	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4701 Willard Ave./20815				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Howard S. Lubel		Ida Meltzer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes WW II		577-12-7672		L. Kenneth Lubel, Silver Spring, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic Ca of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>4 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8b PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>68</u> to <u>10-18</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-15-87</u> 19 <u></u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Bernard Ostrow</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>10-19-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard Ostrow				22e. ADDRESS 5225 Pooks Hill Rd., Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		10/20/87		Mt. Comfort Crematory		Alexandria, VA			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			
				OCT 28 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) C. Murray		FIRST MIDDLE LAST LYON		2a DATE OF DEATH MONTH DAY YEAR October 28 1987		2b HOUR 0230 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a BIRTHPLACE (COUNTRY) Canada		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Rockville		11c NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical		12b KIND OF BUSINESS OR INDUSTRY Engineer	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Clifford Randolph Lyon		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Irene Sharp		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WW2 & Korea 184-12-3576	
17 INFORMANT Jane Lyon,		ADDRESS Item 13		18 CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>PROGRESSIVE Dementia</u> (c) <u>Chronic Renal Failure</u> Conditions, if any, which gave rise to immediate cause - (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, FOR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>July 19 87</u> to <u>October 27 19 87</u> that (I) (we) last saw the deceased alive on <u>October 26 19 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/29/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Vaccarella		22e ADDRESS 6246 Montrose Rd Rockville					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 29, 1987		23c NAME OF CEMETERY OR CREMATORY Westview		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.,		ADDRESS Damascus, Md.		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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W. H. H. H.

RECEIVED

10-11-57

10-11-57

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) Nettie O Mace			7a DATE OF DEATH MONTH DAY YEAR 10 24 87		7b HOUR 5 07 AM
3 SEX Female	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR 2 8 92	6 AGE (IN YEARS LAST BIRTHDAY) 95	IF UNDER 1 YEAR MONTH DAY HOUR MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND			13b COUNTY MONTGOMERY	13c CITY OR TOWN KENSINGTON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e STREET ADDRESS / ZIP CODE 9915 WILDWOOD ROAD 20895					
14 FATHER'S NAME FIRST MIDDLE LAST AUGUST OFFERMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 578-48-0648		17 INFORMANT DOROTHY M. DEAN/DAUGHTER/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute inferior posterior myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (the hospital) attended the deceased from July 19 83 to October 24 1987 that (1) (was) last saw the deceased alive on October 24 1987 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (did) (not) view the body after death					
22b SIGNATURE Michael Lincoln M.D.				22c DATE SIGNED 10/24/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Lincoln, M.D.				22e ADDRESS 10313 Georgia Ave Silver Spring Md. 20902	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT27,1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM	
23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD					
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a DATE REC'D. BY REGISTRAR OCT 29 1987	
				25b REGISTRAR'S SIGNATURE John Deason-Richard	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30033

1. FOR STATE REGISTRAR James Edward Maddox		REG. NO.	
2a. DECEASED NAME (TYPE OR PRINT) James Edward MADDox		2b. DATE OF DEATH MONTH DAY YEAR 10-28-87	
3 SEX Male		4 RACE White	
5 DATE OF BIRTH MONTH DAY YEAR March 12 1926		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Holonist Hospital	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming	
13a STATE Maryland		13b COUNTY Montgomery	
13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 8312 McCullough Lane, Apt. 101		14 FATHER'S NAME FIRST MIDDLE LAST Sidney Fletcher Maddox	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louzella Brinkley		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII	
16b SOCIAL SECURITY NO 230-20-0262		17 INFORMANT ADDRESS Evelyn Maddox, Gaithersburg, Md. 20877	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Salmonella enteritis			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:28 P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 5 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (the hospital) attended the deceased from October 23, 19 87 to October 28, 19 87 that (1) (the hospital) saw the deceased alive on 10/28 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did (did not) view the body after death.			
22b SIGNATURE Alan S. Chanaler		22c DATE SIGNED 10/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALER		22e ADDRESS 15225 SHADY GROVE RD ROCKVILLE	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 31, 1987	
23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24 FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md. 20879		25a DATE REC'D. BY REGISTRAR NOV 2 1987	
25b REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified of cause.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30034

1 DECEASED NAME (TYPE OR PRINT) FIRST: <u>LOUIS</u> MIDDLE: LAST: <u>MAIZEL</u>				2a DATE OF DEATH MONTH: <u>10</u> DAY: <u>19</u> YEAR: <u>87</u>				2b HOUR <u>7:45</u> M.	
3 SEX <u>MALE</u>		4 RACE <u>CAUC.</u>		5 DATE OF BIRTH MONTH: <u>8</u> DAY: <u>30</u> YEAR: <u>20</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.		IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ARGENTINA</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.			
10 CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLT CROSS</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Business Owner (Ret.)</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
13a STATE <u>MD</u>		13b COUNTY <u>MONT.</u>		13c CITY OR TOWN <u>SILVER SPRING</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>316 BEAUMONT RD. (20904)</u>	
14 FATHER'S NAME FIRST: <u>George</u> MIDDLE: LAST: <u>Maizel</u>				15 MOTHER'S MAIDEN NAME FIRST: <u>Sarah</u> MIDDLE: LAST: <u>Hofberg</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u>		16b SOCIAL SECURITY NO <u>1944-1949</u>		16c SOCIAL SECURITY NO <u>578-18-8471</u>		17 INFORMANT <u>Rose V. Maizel; Wife; 316 Beaumont Road;</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC GASTRIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>ATHEROSCLEROTIC HEART DISEASE</u>									
19a DATE OF OPERATION <u>10/1/87</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GASTRIC CARCINOMA</u>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART 1 OR PART 2)					
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 19 87</u> to <u>Oct 19 87</u> that I (we) last saw the deceased alive on <u>Oct 18 87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Alan Diamond</u>				DEGREE <u>MD</u>				22c DATE SIGNED <u>10/19/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALAN DIAMOND</u>				22e ADDRESS <u>1106 SPRING ST SILVER SPRING MD</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>10/21/87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Judean Memorial Garden</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Olney; Montgomery; Maryland</u>			
24 FUNERAL DIRECTOR NAME <u>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</u>				24b ADDRESS <u>1170 Rockville Pike; Rockville, Md. 20852</u>		25a DATE RECEIVED BY REGISTRAR <u>OCT 21 1987</u>			
25b REGISTRAR'S SIGNATURE									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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070527 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove column papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 27 is marked by item 18 unless any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Daisy A Mance</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 25 87</i>			2b HOUR <i>0800 M</i>			
3 SEX <i>F</i>		4 RACE <i>B</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>8 27 18</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <i>69</i>		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN <i>10 25 87</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Georgia</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MD</i>			
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
13a STATE <i>MD.</i>		13b COUNTY <i>P.G.</i>		13c CITY OR TOWN <i>Takoma Park</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>7620 Maple Avenue, #301</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Lem King</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Daisy Alexandria</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Not Stated</i>		17 INFORMANT ADDRESS <i>Norma Bess Friend 4552 Argyle Terr NW.</i>					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

Septicemia Permanent Pacemaker Prosthetic Aortic Valve

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>10/16</i> 19 <i>87</i> to <i>10/25</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>10/24</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Antonio H. Uy</i>				DEGREE <i>M.D.</i>		22c DATE SIGNED <i>10/25/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANTONIO G. UY</i>				22e ADDRESS <i>831 Univ. Blvd. E. #25, S.S. 11d 20903</i>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>29 Oct 87</i>		23c NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Maryland</i>	
24 FUNERAL DIRECTOR NAME ADDRESS <i>Frazier's Funeral Home 389 Rhode Island Avenue, Wash., D.C.</i>				25a DATE REC'D. BY REGISTRAR <i>OCT 30 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

069819 00 27-87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Williams Swift Martin			2a. DATE OF DEATH MONTH DAY YEAR Oct. 10, 1987		2b. HOUR 3:00A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill - Bethesda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mining Engineer	12b. KIND OF BUSINESS OR INDUSTRY Pvt. Industry	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13c. CITY OR TOWN Washington, DC		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2915 Q Street, N.W./20007	
14. FATHER'S NAME FIRST MIDDLE LAST Williams Swift Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie English Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 110-24-0622	17. INFORMANT ADDRESS Williams S. Martin, III, 4819 Quebec St., NW, Washington, D.C. 20016			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) PARKINSON DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10+ years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 18 19 87 to OCTOBER 10 19 87 that (I) (we) last saw the deceased alive on September 25 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert V. Choisser		DEGREE MD		22c. DATE SIGNED OCT. 10, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. Choisser		22e. ADDRESS 5530 Wisconsin Ave., Chevy Chase, MD 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/12/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA	
24. FUNERAL DIRECTOR (NAME) Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR OCT 26 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

100-101, 102, 103

уточняю

Machine Engineer, Ivt. Industry

SALES & SERVICE, INC., 1000 N. 10TH ST., SUITE 100, DENVER, CO 80202

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x

10/12/67 Mt. Comfort Crematory Alexandria, VA

710, Madison Ave., New York, N.Y.
Joseph P. ...

068927 OCT 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond Nathan. Matson			2a. DATE OF DEATH MONTH DAY YEAR October 14, 1987		2b. HOUR 7:05 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 21, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9503 Bruce Dr. Silver Sprg.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Patent Agent		12b. KIND OF BUSINESS OR INDUSTRY Self Employed
13a. STATE Maryland.		13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring.	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	13e. STREET ADDRESS 9503 Bruce Dr. Silver Sprg.
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Matson.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Birge.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 219-01-5037		17. INFORMANT ADDRESS A. Cornelia K. Matson. Wife. 13 E.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) with congestive failure + fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years Several years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Emphysema, advanced					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1955 19 to October 14, 1987 that (I) (we) last saw the deceased alive on October 14, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bennet A. Porter, Jr. M.D.				22c. DATE SIGNED October 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bennet A. Porter, Jr. M.D.				22e. ADDRESS 9301 Coleridge Rd, Silver Spring, Md. 20901	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE Oct. 15, 1987		23c. NAME OF CEMETERY OR CREMATORY George Washington Riggs Rd. Adelphi, Md	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, Inc		24b. ADDRESS 254 Carroll St. N. W. D. C.		24c. DATE RECEIVED BY REGISTRAR OCT 16 1987	
24d. REGISTRAR'S SIGNATURE Julia Denton					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified of a case.

BP

069894 OCT 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Natalie		FIRST MIDDLE LAST Natalie Matthay		2a DATE OF DEATH MONTH DAY YEAR 10 21 87		2b HOUR 16:30 P M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8 28 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own home	
13a STATE Florida		13b COUNTY Palm Beach		13c CITY OR TOWN Delray Beach		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME (FIRST MIDDLE LAST) (Unavailable) Zelensky		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Unavailable		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 645-38-6490	
17 INFORMANT ADDRESS 6016 McKinley Street Bethesda, MD 20817		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GANGRENOUS right leg</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 72 hrs 5 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>NO</u>							
19a DATE OF OPERATION 13 Oct 87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ischemia right leg		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <u>Sept 30</u> 19 <u>87</u> to <u>Oct 21</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>Oct 21</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.							
22b SIGNATURE Hugh H. Trout III MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 22 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Hugh H. Trout III		22e ADDRESS 8218 Wisconsin Ave Bethesda MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-22-87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010				25a DATE REC'D BY REGISTRAR OCT 26 1987			
				25b REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12
069506 OCT 23 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30039

1- FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

WILLIAM

FIRST

MIDDLE

(LAST)

MAXIN

7a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

October 9, 1987

11:00A_M

3 SEX

Male

4 RACE

Caucasian

5. DATE OF BIRTH

August 22, 1912

6 AGE (IN YEARS LAST BIRTHDAY)

75

YRS

7b. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

Philadelphia, Pa.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10 CITY OR TOWN OF DEATH

Rockville, Md.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Potomac Valley Nursing Home

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retailer-Shoes

12b. KIND OF BUSINESS OR
INDUSTRY

Childrens Shoes

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

New York

13b. COUNTY

East Williston

13c. CITY OR TOWN

YES ☐ NO ☐

13d. INSIDE CITY LIMITS?

99 Bengay Field Rd. 11596

14 FATHER'S NAME

Joseph

MIDDLE

Maxin

15 MOTHER'S MAIDEN NAME

Sarah

MIDDLE

(unascertainable)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

186-07-3714

17 INFORMANT

Adele Maxin East Williston, New York

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Asthma's Disrupt

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16, PART I OR PART II)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from MAY 29, 1987 to 10/9 1987 that (I/we) last
saw the deceased alive on 10/9/87 and that in (my/our) opinion death occurred on the date and hour and from the causes stated
above. (I/we) did/did not view the body after death.

22b. SIGNATURE

Myron L. Lenkin

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

10/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Myron L. Lenkin, M. D.

22e. ADDRESS

2309 Shorefield Rd. Wheaton, Md. 20902

23a. BURIAL, CREMATION, REMOVAL
(TYPE IF 1)

Burial

23b. DATE

Oct. 11, 1987

23c. NAME OF CEMETERY OR CREMATORY

Beth Moses

23d. LOCATION
CITY OR TOWN

Pine Lawn L. I. N.Y.

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME

25a. DATE REC'D. BY REGISTRAR

OCT 15 1987

25b. REGISTRAR'S SIGNATURE

John E. Gordon-Rodriguez

1162139 007030

069583

OCT 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CHARLES RICHARD MAXWELL			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 11 1987			2b HOUR P 8:10			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR APRIL 15 1915		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY PUBLIC HEALTH	
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN BETHESDA		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST EDWIN RUFUS MAXWELL			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE HOLMAN			13e STREET ADDRESS / ZIP CODE 4510 GRETNA STREET 20814			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-1972		17 INFORMANT ADDRESS ELIZABETH S. MAXWELL, 4510 GRETNA STREET.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 912 IMMEDIATE CAUSE (a) MULTI INFARCT DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ASPIRATION, RIGHT MIDDLE LOBE PNEUMONIA AND DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 7, 19 87, to OCTOBER 11, 19 87, that (I) (we) last saw the deceased alive on OCTOBER 11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE T. X. DWYER, LT, MC, USNR						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 14 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) T. X. DWYER, LT, MC, USNR						22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10-14-87		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24 FUNERAL DIRECTOR J. William Lee's Sons Company 300 4th St. N.E. Washington, D.C. 20002						25a DATE REC'D. BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rodell	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers, pages 1 and 2, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John S. Sr Maykuth		2a. DATE OF DEATH MONTH DAY YEAR 10-23-87		2b. HOUR 3:28 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 18, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21415 Uppermont Lane 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Steven Maykuth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Tephican			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 211-05-3163		17. INFORMANT ADDRESS John S. Maykuth, Jr (son) Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a <u>Pneumonia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 1985</u> to <u>October 23, 1987</u> that (I) (we) last saw the deceased alive on <u>October 23, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>October 24, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. H. AINE H. ETG</u>		22e. ADDRESS <u>Pro 1 George Lane Silver Spring Md 20902</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26 Oct 87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
23d. LOCATION (CITY OR TOWN COUNTY STATE) Washington County, Penna.					
24. FUNERAL DIRECTOR NAME ADDRESS Capitol Funeral Service, Falls Church, VA		25a. DATE REC'D. BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "I" above, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

70171 OCT 20 87

John

June 15, 1942

Tommy

U.S.A.

x

University of

silver

1015 Street

1015

1015

University of

x

University of

Steven

Steven

Ann

1015

11-12-316 June 15, 1942, Dr. (son) June 15

Bureau

17 Oct 87

Mr. Calvary Cemetery

Capital Federal Service, Falls Church, VA

OCT 18 1987

069567 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Michael B McCartan			2a DATE OF DEATH MONTH DAY YEAR October 15, 1987			2b HOUR 3 P M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1960		6 AGE (IN YEARS LAST BIRTHDAY) 27		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Financial analyst		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Wheaton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 11419 Viers Mill Rd. 20902	
14 FATHER'S NAME FIRST MIDDLE LAST C. BERNARD McCartan			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Walsh			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO 221-60-8939			17 INFORMANT C. Bernard McCartan			ADDRESS Newark, Del. 19713 152 Brookside Blvd			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE RESPIRATORY DISTRESS SYNDROME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYELOMONOCYTIC LEUKEMIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY 5 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) the hospital attended the deceased from OCTOBER 10, 1987 to OCTOBER 15, 1987 that (1) the deceased alive on OCTOBER 15, 1987 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (1) <input type="checkbox"/> did not view the body after death.									
22b SIGNATURE James A. Brown, M.D.						DEGREE		22c DATE SIGNED 10/15/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, M.D.						22e ADDRESS 14801 PHYSICIANS LANE ROCKVILLE MD 20850			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/20/87		23c NAME OF CEMETERY OR CREMATORY All Saints Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Newark, New Castle, Del.		
24 FUNERAL DIRECTOR NAME ADDRESS Robert J. Fox Newark, Del.						25a DATE REC'D. BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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069306 OCT 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Jon Robert McIntyre			2a DATE OF DEATH MONTH DAY YEAR October 1, 1987			2b HOUR 12:30 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 1, 1987		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 2 1 2		7b HOUR 12:30 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? Maryland		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 9426 Gentle Circle 20879	
14 FATHER'S NAME FIRST MIDDLE LAST James Jon McIntyre				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Roberta Ann Cleland					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extreme Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hr.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>87</u> , to <u>10-1</u> , 19 <u>87</u> that (2) (we) last saw the deceased alive on <u>10-1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Robert Buczek M.D.</u>				DEGREE MD				22c DATE SIGNED 10-2-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert Buczek M.D.				22e ADDRESS Shady Grove Hosp. Rockville MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE UNKNOWN		23c NAME OF CEMETERY OR CREMATORY UNKNOWN		23d LOCATION CITY OR TOWN COUNTY STATE UNKNOWN			
24 FUNERAL DIRECTOR NAME UNKNOWN				ADDRESS		25a DATE REC'D BY REGISTRAR OCT 07 1987		25b REGISTRAR'S SIGNATURE	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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NOV - 3 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Alfred J. McKenzie			2a DATE OF DEATH MONTH DAY YEAR 10/28/87			2b HOUR 12:00pm				
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 6/22/06		6 AGE (IN YEARS LAST BIRTHDAY) 81		7 UNDER 1 YEAR MONTHS DAYS 10/28/87		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bonding		12b KIND OF BUSINESS OR INDUSTRY Insurance Co.		
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12532 War Admiral Way/20878	
14 FATHER'S NAME FIRST MIDDLE LAST Alexander McKenzie				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Davidson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-30-7883		17 INFORMANT ADDRESS Alexandra M. Smith, same as #13					
18 CAUSE OF DEATH Enter only one cause per line for PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Septicemia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/28/87		
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from Oct 10 19 87 to Oct 28 19 87 that (1) (we) last saw the deceased alive on Oct 29 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b SIGNATURE John E. Dordick, M.D.					DEGREE MD					
22c PHYSICIAN'S NAME (TYPE OR PRINT) John E. Dordick, M.D.					22d ADDRESS 17504 62nd Ave, Haverhill, MA 01907					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 31, 1987		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION (CITY OR TOWN) COUNTY STATE Silver Spring, Maryland			
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850						25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE John E. Dordick		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

68321 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Shannon

Anne

McMillan

2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2b. HOUR
M

3 SEX

4 RACE

5 DATE OF BIRTH

6 AGE (IN YEARS)

IF UNDER 1 YR

IF UNDER 24 HRS

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

2d. HOUR

Female

White

Sept. 3, 1965

22 YRS.

MONTHS

DAYS

HOURS

MIN

10-5-87

19

10:25

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

California

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10 CITY OR TOWN OF DEATH

Silver Spring

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

3318 Parkford Manor Terrace

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Legal Secretary

12b KIND OF BUSINESS OR INDUSTRY

Legal Office

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS

3318 Parkford Manor Terrace #K

14 FATHER'S NAME

Frank

MIDDLE

D.

LAST

McMillan

15 MOTHER'S MAIDEN NAME

Patricia

MIDDLE

Wedin

LAST

Wedin

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

467-53-2202

17 INFORMANT

Edward I. Smith, Jr. Fairfax, Va. 22032

5337 Crisfield Court,

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a). Multiple stab wounds

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 10-4-1987

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Subject stabbed

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

home

21f LOCATION

3318 Parkford Manor Terrace, Silver Spring, Montgomery county, MD

22a I certify that I took charge of the remains described above, held an

Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

death resulted from

Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

M.D.

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE 10-6-87

SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

Charles F. Kokes, M.D.

ADDRESS

111 Penn Street, balto., MD 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

Oct. 9, 1987

23c NAME OF CEMETERY OR CREMATORY

Fairfax Memorial Park

23d LOCATION (CITY OR TOWN)

Fairfax, Va.

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

ADDRESS

Money & King Funeral Home, 171 W. Maple Ave.

Vienna, Va. 22180

25a DATE REC'D. BY REGISTRAR

OCT 09 1987

25b REGISTRAR'S SIGNATURE

John Fairclough Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

88351 OCT 13 61



88351 OCT 13 61

068763 OCT 16 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HARVEY CLYDE MELICK			2a. DATE OF DEATH MONTH DAY YEAR 10-6-87			2b. HOUR 7P M		
3 SEX male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-18-06		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS 6		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD				
10 CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHARON NURSING Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CIVIL ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY ENGINEERING		
13a STATE MD.		13b COUNTY MONTGOMERY	13c CITY OR TOWN SANDYSPRING	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 17701 Dominion Dr. 20860			
14 FATHER'S NAME FIRST MIDDLE LAST Simon V. Melick		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA M. CONKLIN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NONE		16b SOCIAL SECURITY NO. 101-03-0443A		17 INFORMANT ADDRESS GARY MELICK 3300 KEN ALLEN CT. GREENWOOD, MD.				
18 CAUSE OF DEATH (Enter: only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from October 19, 86 to October 19, 87 , that (I) (we) last saw the deceased alive on 9-19-87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b SIGNATURE T. Howe, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-6-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) TED E. HOWE MD		22e ADDRESS OLNEY, MARYLAND						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCT. 7, 1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG CO MARYLAND		
24 FUNERAL DIRECTOR NAME ADDRESS CHAMBERS Funeral Home Silver Spring, Maryland				25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 15 1987				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove out-of-pocket pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment, or other final disposition.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

088703 OCT 15 87

WILLIAM H. HICKS

20% COTTON FIBRE

100% COTTON FIBRE

OCT 15 887

068048 OCT

FOR
STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE KNOWN OF ESTI DEATH MATED		MONTH		DAY		YEAR		2b HOUR	
Richard		L.		Mendolia				10-1		19		87				M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	2 11 1939		48 YRS		MONTHS		DAYS		10-1		19		87		6:20A	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 BALTIMORE CITY OR COUNTY OF DEATH									
New York		U. S. A.		WIDOWED		DIVORCED		Montgomery County								MD	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY											
Chevy Chase		5520 Wisconsin Avenue (parking lot)		Chauffer		Transportation											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS									
New York		Queens		Ridgewood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		607 Fairview Ave.									
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME															
Jack		Helen															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
Yes		Peacetime		133-30-6861		Victor Mendolia		74 Arpage Dr. East Shirley,									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
						DUE TO, OR AS A CONSEQUENCE OF											
						(b)											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a I certify that I took charge of the remains described above, held an death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		10-2-87									
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.		ADDRESS		111 Penn Street, Baltimore, MD 21201											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		10-6-87		Lutheran Cemetery		Middle Village, Queens, New York											
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
Marzullo Funeral Service		Upperco, MD.		OCT 06 1987		Julia Davidson-Rudess											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH 17
(VR A15 ME (1))

08004000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their plates should have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other cause of event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 DECEASED NAME (TYPE OR PRINT) Edith L. Menkel				2a DATE OF DEATH MONTH DAY YEAR 10 4 87				2b HOUR 3:00 p M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Oct. 2, 1897		6 AGE (IN YEARS, LAST BIRTHDAY) 89		7b HOUR 3:00 p M	
7a BIRTHPLACE (COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN LUSH FACILITY, GIVE STREET ADDRESS) National Lutheran Home		12a USUAL OCCUPATION (TYPE OR PRINT, GIVE WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Education			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Balt. City		13b CITY OR TOWN Baltimore		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2901-Guilford Ave. 21218			
14 FATHER'S NAME FIRST MIDDLE LAST Frederick - Menkel				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna A.B. Ernst					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 214-40-3708		17 INFORMANT ADDRESS Rev. Dr. Reichard - N.L.H. - Rockville, Md					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EXTENSIVE METASTATIC CA. UNKNOWN CELL TYPE DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Subacute									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3 OR PART 4)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (A) WORK (A) WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) the hospital attended the deceased from <u>March 19 85</u> to <u>Oct 4</u> 19 <u>91</u> that (2) I viewed the deceased alive on <u>Oct 4, 1991</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above <u>if we did, did not</u> view the body after death.									
22b SIGNATURE <u>Thomas E. Doherty, M.D.</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>Oct 12, 1991</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOHERTY, M.D.				22e ADDRESS 17904 BEACON AVE CLAY, MARYLAND 20732					
23a BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b DATE OCT. 8, 1987		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24 FUNERAL DIRECTOR NAME HYSONG CO., INC - 1300 N ST., NW WASH., DC				25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE <u>William R. Linder</u>			

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WAT FILL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG NO

1 DECEASED NAME (PRINT) myrtle Joan Merson			2a DATE OF DEATH MONTH DAY YEAR 10-21-87			2b HOUR 2320 M				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 29, 1928		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD				
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		12b KIND OF BUSINESS OR INDUSTRY School				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Damascus		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 9703 Beall Ave., 20872	
14 FATHER'S NAME FIRST MIDDLE LAST Walter J. Klawonn			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle B. Slayman							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 579-32-9420		17 INFORMANT Harry B. Merson		Item 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Long Cancer with brain metastasis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>epistaxis and possible intestinal bleeding</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		21g CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 1985 to 10/21 1987, that (I) (we) last saw the deceased alive on 10/21 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Susan J. Withrow MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 10/22/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Susan J. Withrow			22e ADDRESS 15225 Shady Grove Rd # 105, Rockville Md 20850							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 24, 1987		23c NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.			
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a DATE REC'D. BY REGISTRAR OCT 26 1987		25b REGISTRAR'S SIGNATURE		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove this page. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>LYLE WAYNE MILLS</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10-8-87</u>		2b. HOUR <u>1:58 PM</u>	
3. SEX <u>M</u>		4. RACE <u>C</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>12 08 05</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Owner</u>		
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Springs</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>David alexander Mills</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Pancoast NMN Henry</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>578-46-9507</u>		17. INFORMANT <u>Helen C. Mills, 614 Sligo Ave., Silver Springs, Md. 20910</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration with cardiac and pulm. resp arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24/87</u> 19 to <u>10/8/87</u> 19 that (I) (we) last saw the deceased alive on <u>10/8/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE <u>Michael S. H...</u>				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SMITH Ho</u>				22e. ADDRESS <u>7610 Carroll Ave, Takoma Park, Md 20912</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-14-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		
24. FUNERAL DIRECTOR (NAME) <u>C. Warren Lerner</u>		24b. ADDRESS <u>1200 N. Shenandoah Ave. Front Royal, Virginia</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 15 1987</u>		
				25b. REGISTRAR'S SIGNATURE <u>Davidson R...</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Front Royal, Warren, Virginia</u>						

MEDICAL CERTIFICATION

IMPORTANT: If item 27 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove completed pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the cause of death is not a traumatic event, the medical examiner will be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR 2. BASED NAME FIRST MIDDLE LAST FANNIE MINDEL				2a. DATE OF DEATH MONTH DAY YEAR October 13, 1987			
3. SEX Female				2b. HOUR 2:10a.m.			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) -81 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Rosenberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Susel		13e. STREET ADDRESS / ZIP CODE (20853) 12630 Viers Mill Road, #1312;			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-70-4610		17. INFORMANT #1312; Rockville, Md. 20853 Abraham Mindel; Husband; 12630 Viers Mill Rd.;			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Natural Cause</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10/11/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> 19 <u>87</u> to <u>10/13</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/12</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Penny L. Bisk				DEGREE M.D.		22c. DATE SIGNED Oct. 13, 1987	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY L. BISK, M.D.				22e. ADDRESS 10313 Georgia Avenue; Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR OCT 16 1987			

000001 OCT 1901

[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page]

069057 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Katie MOERMAN			2a DATE OF DEATH MONTH DAY YEAR 10-18-87			2b HOUR MIN 12:30 P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 9-15-1893		6 AGE (IN YEARS LAST BIRTHDAY) YRS 99		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6121 Montrose Road 20852	
14 FATHER'S NAME FIRST MIDDLE LAST (Unknown)					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-94-0355		17 INFORMANT ADDRESS 18 Stearnmore Court Samuel H. Moerman Potomac, Md. 20854					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Uncontrolled Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: g									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 6-1 19 83 to 10-18 19 87 , that (I) (we) just saw the deceased alive on 10-18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Loreto S. Albiol, MD						DEGREE MD		22c DATE SIGNED 10-18-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Loreto S. Albiol						22e ADDRESS 6121 MONTROSE RD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/19/1987		23c NAME OF CEMETERY OR CREMATORY Ono Shalom Talmud Torah Congregation		23d LOCATION CITY OR TOWN COUNTY STATE Washington D. C.		
24a DONATION DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME						24b DATE REC'D. BY REGISTRAR OCT 21 1987			
24c ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.						24d REGISTRAR'S SIGNATURE Landon R. ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages head 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 50M 1/81
(VRA 15, 4)

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CONFIDENTIAL

68310 OCT 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Richard W. Molineu				2a DATE OF DEATH MONTH DAY YEAR Oct 5 1987				2b HOUR 9:29 M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 24, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 63		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Switchman		12b KIND OF BUSINESS OR INDUSTRY C&P Tele. Co.	
13a STATE MD		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5011 Adrian ST. 20853	
14 FATHER'S NAME FIRST MIDDLE LAST Herbert W. Molineu				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Zellers					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS Colleen G. Molineu, wife, see #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								b) _____ DUE TO, OR AS A CONSEQUENCE OF	
c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Dec 19 1965 to Oct 5 1987 that (II) (we) lost saw the deceased alive on Oct 5 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Raymond Bradshaw, MD				DEGREE MD				22c DATE SIGNED Oct 6, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Bradshaw				22e ADDRESS 345 University Blvd, W Silver Spring, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 8, 1987		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d LOCATION CITY OR TOWN Rockville, Maryland		COUNTY STATE	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc.				25. DATE REC'D BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE Richard A. ...			
300 W. Montgomery Ave., Rockville, Md									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ALLEN MONCH, JR.			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 7 1987		2b HOUR P M 4:52 P
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JUNE 16 1952		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 35	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE VIRGINIA	13b COUNTY FAIRFAX	13c CITY OR TOWN VIENNA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM ALLEN MONCH, SR		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS WRAY BUTLER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17 INFORMANT ADDRESS GWYN K. MONCH, 2528 GLENGYLE DRIVE, VIENNA, VA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SMALL CELL CANCER OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 23, 19 87 to OCTOBER 7, 19 87 , that (I) (we) last saw the deceased alive on OCTOBER 7, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Edward P. Fox				22c DATE SIGNED Oct. 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT. MC, USN				22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Oct. 9, 1987	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24 FUNERAL DIRECTOR NAME ADDRESS Money & King Funl. Home, Vienna, Virginia			25a DATE REC'D. BY REGISTRAR OCT 14 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3, it should be detached for use as the burial-transit permit. Then please remove the copy of this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M/74
(VRA 15, 4)

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070623 NOV-3-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Joseph Moore			2a DATE OF DEATH MONTH DAY YEAR 10-27-87		2b HOUR 12:30^M
3 SEX Male	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR March 19, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fed. Investigator		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.

13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2319 Peggy Lane (20910)
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14 FATHER'S NAME FIRST MIDDLE LAST Harry Moore		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Janus	
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16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	(IF YES, GIVE WAR OR DATES) WWII	16b SOCIAL SECURITY NO. 577-60-0877	17 INFORMANT ADDRESS Linda Walder; Daughter; 26 Rich Branch Ct.; Gaithersburg, Md. 20878
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
hypertension

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
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21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
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22a I certify that (I) (this hospital) attended the deceased from 10/27/87 to 10/27/87 , that (I) (we) last saw the deceased alive on 10/27/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.	
--	--

22b SIGNATURE Kamela M. P.	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/28/87
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22d PHYSICIAN'S NAME (TYPE OR PRINT) MULSHINE P	22e ADDRESS
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23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/29/87	23c NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens; Olney, Montgomery; Md.	23d LOCATION CITY OR TOWN COUNTY STATE
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24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS	25a DATE REC'D BY REGISTRAR NOV 2 1987	25b REGISTRAR'S SIGNATURE John F. Anderson
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1170 Rockville Pike; Rockville, Md. 20852

NOV 2 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon plates, pages 1 and 2, and mail them within 72 hours after death to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		X MONTH		DAY		YEAR		2b. HOUR	
Phillip James Moreland								ESTIMATED		10		24		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	March 3, 1963		19 YRS.						10		24		87		12:10 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		American		WIDOWED		DIVORCED		Montgomery County								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Laytonville		Rt. 108 & Warfield Rd.		Landscaper													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montg.		Germantown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11607 Summer Oak Drive									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Phillip		Kenneth		Moreland		Linda		S.		Turner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		215-98-3695		Phillip K. Moreland		Item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under</u> <u>lying</u> <u>cause</u> <u>lost</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
		12:01 AM 10 24 1987		Driver of auto lost control & struck tree													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		road		Rt. 108 & Warfield Rd, Laytonville, Mont. MD.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.										DATE SIGNED		10/24/87			
		Assistant MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.										ADDRESS		111 Penn St. Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE							
Burial		10/27/87		Pine Grove Cemetery		Mt. Airy Carroll Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, P.A.		Damascus, Md.										OCT 27 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR REVIEW. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

RECEIVED
JUL 11 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



ADDITIONAL PAGE

[Handwritten signature]

TO : DIRECTOR, FBI (100-100000)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

100-100000
JUL 11 1964
FBI NEW YORK

068151 OCT 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Bessie Moss				2a DATE OF DEATH MONTH DAY YEAR 10-5-87				2b HOUR 05 6 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 2-2-03		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY AT HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND				13b COUNTY BALTO.		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST LOUIS GOLDSMITH				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-6351		17 INFORMANT MRS. RHODA OBERFELD APT. 713 261 CONGRESSIONAL LA. ROCKVILLE, MD 20852					
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY DISTRESS SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNDEFINED ORIGIN</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS 2-3 DAYS —	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>INTESTINAL OBSTRUCTION - UPPER G.I. BLEEDING</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>JULY 87</u> to <u>OCT. 5, 87</u> that (I) (we) last saw the deceased alive on <u>OCT 4, 1987</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Lawrence J. Marcus, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE J. MARCUS, M.D.				22e ADDRESS 10313 GEORGIA AVE. #207, SILVER SPRING, MD 20902					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT. 6, 1987		23c NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a DATE REC'D BY REGISTRAR OCT 08 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

070581 NOV-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST mamie S. moy			2a DATE OF DEATH MONTH DAY YEAR 10-31-87		2b HOUR 2:19 A	
3 SEX Female		4 RACE Oriental		5 DATE OF BIRTH MONTH DAY YEAR August 28, 1904		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		8 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home				
13a STATE Alabama		13b COUNTY Mobile		13c CITY OR TOWN Mobile		
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 650 Montcliff Drive, W./33609				
14 FATHER'S NAME FIRST MIDDLE LAST Mark Shue		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS Mrs. Dorothy M. Chin, Daughter, Same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>st. cerebral embolus with secondary cerebral herniation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <u>years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 19 <u>85</u> to <u>10, 31</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10/30</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death						
22b SIGNATURE Frauke Westphal		DEGREE MD		22c DATE SIGNED Oct. 31, 1987		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.		22e ADDRESS 809 Viers Mill Road Rockville, Maryland 20851				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b DATE November 2, 1987		23c NAME OF CEMETERY OR CREMATORY Whitemarsh Memorial Pk. Prospectville Pennsylvania		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue, Rockville, MD. 20850		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Lisa Anderson-Pandue		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070501 NW-301

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

2a DECEASED NAME (PRINT) <i>Lamie H. Muse</i>		2b DATE KNOWN OF DEATH ESTIMATED <i>Oct 12 1987</i>	
3 SEX <i>M</i>	4 RACE <i>Black</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>April 12 1950</i>	6 AGE (IN YEARS) LAST BIRTHDAY YRS <i>37</i>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10 CITY OR TOWN OF DEATH <i>Tak Park</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent Hosp</i>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BRICKLAYER</i>		12b KIND OF BUSINESS OR INDUSTRY <i>PRIVATE</i>	
13a STATE <i>DC</i>		13b CITY OR TOWN <i>Washington</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>CHARLIE MUSE</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MATTIE GOGGINS</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>		16b SOCIAL SECURITY NO. <i>7-27-456 8-214 228-28-0556</i>	
17 INFORMANT <i>Betty Muse</i>		ADDRESS <i>927 Hamilton St N.W. Washington, D.C.</i>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION <i>None</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) <i>Dep.</i>		DATE SIGNED <i>Oct 12 1987</i>
ACTUAL SIGNATURE <i>John S. Rogers</i>		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>		ADDRESS		

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b DATE <i>10-16-87</i>	23c NAME OF CEMETERY OR CREMATORY <i>HARMONY MEM. PARK</i>	23d LOCATION CITY OR TOWN COUNTY STATE <i>LANDOVER P.G. Maryland</i>
24 FUNERAL DIRECTOR NAME ADDRESS <i>JOHNSON & JENKINS, FH INC WASH. D.C.</i>		25a DATE REC'D BY REGISTRAR <i>OCT 22 1987</i>	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

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DHMH - 17
(VR A15 ME (1))

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

DECEASED NAME (OR PRINT) Beulah M. Myles		2a. DATE KNOWN OF DEATH ESTIMATED Oct 10, 1987		2b. DATE OF DEATH MONTH DAY YEAR Oct 10, 1987	
1. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 25, 1908	6. AGE (IN YEARS) YRS 79	IF UNDER 1 YR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH St. Spgs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	
13a. STATE MD		13b. CITY OR TOWN Washington, DC		13c. STREET ADDRESS 5415 Connecticut Ave, NW/20015	
14. FATHER'S NAME FIRST Benjamin MIDDLE --- LAST Myles		15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE --- LAST Leatherwood		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 579-30-7589		17. INFORMANT Ralph F. Myles, Hyattsville, MD 20783			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY STREET, FACTORY, FARM, ETC.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Doc		MEDICAL EXAMINER DATE SIGNED Oct 10, 1987	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Montg. Co., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN Suitland, MD		COUNTY		STATE	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR OCT 16 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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BP
FORM 1-7
(VR A15 ME 15)

068170 OCT 20 07

U.S.A. X

Maryland

U.S.A.

X

Accountant

Pub. Gov't.

2415 Connecticut Ave, NW, 20015

Washington, DC

Leatherwood

--

Home

U.S.A.

--

Benjamin

900 Somerset Place

Hyattsville, MD 20785

202-50-7589

No

Silver Spring, Mont. Co., MD

John E. Rogers

Switzland, MD

Cedar Hill Cemetery

10/17/87

Burial

Joseph Gwiler's Sons, Inc.
5130 Wisconsin Ave, NW, Washington, D.C. 20016

69716 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) CLAUDIA JOAN NELSON JR.			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 20, 1987		2b HOUR 12:15P ^M
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JANUARY 11, 1952		6 AGE (IN YEARS LAST BIRTHDAY) 35 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 15 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN) CALIFORNIA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b KIND OF BUSINESS OR INDUSTRY OWN HOME
13a STATE MARYLAND		13b COUNTY HOWARD	13c CITY OR TOWN COLUMBIA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST DON SPARKS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARILYN PATRICIA POWELL		13e STREET ADDRESS / ZIP CODE 7121 BANJO CT. 21045	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 551-88-5793		17 INFORMANT ADDRESS CARL NELSON SAME AS 3# 13	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 y ear.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>SEPTEMBER 24</u> , 19 <u>85</u> , to <u>OCTOBER 20</u> , 19 <u>87</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>OCTOBER 20</u> , 19 <u>87</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b SIGNATURE <u>V. Jain</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10-21-87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>VINAY K. JAIN.</u>		22e ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE, PIKE, BETHESDA, MD 20892			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b DATE 10/22/87	23c NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE. CATONSVILLE MD 21228		25a DATE REC'D BY REGISTRAR OCT 23 1987		25b REGISTRAR'S SIGNATURE <u>Julia Denson-Randall</u>	

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joella W. Niemoller			7a DATE OF DEATH MONTH DAY YEAR October 12, 1987		7b HOUR 6:00am
2 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 23, 1937	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Education			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg	
14 FATHER'S NAME FIRST MIDDLE LAST Willie Reno		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Snider		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 500-40-7172		17 INFORMANT ADDRESS Douglas L. Niemoller 18621 Calypso Place Gaithersburg, Maryland 20879	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Gram Negative Bacteremia with E. coli</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <u>8/1</u> 19 <u>86</u> to <u>10/12</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b SIGNATURE <u>Stephen J. Newman</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10/12/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman, M.D.		22e ADDRESS 19261 Montgomery Village Ave. Gaithersburg, Maryland 20879			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 16, 1987		23c NAME OF CEMETERY OR CREMATORY Hopedale Cemetery	
23d LOCATION CITY OR TOWN Ozark		COUNTY Missouri		STATE	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/Rockville Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850				25a DATE REC'D BY REGISTRAR OCT 16 1987	
25b REGISTRAR'S SIGNATURE <u>Jules Gordon-Randall</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY Quang NONE			2a DATE OF DEATH MONTH DAY YEAR 10 / 30 / 87		2b HOUR 0310 A M
3 SEX Male	4 RACE ORIENTAL	5. DATE OF BIRTH MONTH DAY YEAR 1 08 35	6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vietnam	
7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator	
12b KIND OF BUSINESS OR INDUSTRY Solarex Co.					
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Thep Dinh Nong			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Que Thi Do		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 586-40-2909		17 INFORMANT ADDRESS Yvette Dai Nong, same as #13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic cancer lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY SYSTEM (B. PART 1) OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>10/29/87</u> to <u>Oct 30 87</u> that (I) (we) last saw the deceased alive on <u>10/29/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Martin O. Welfz		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Martin Welfz		22e ADDRESS 7525 Greenway Ct Oran Greenbelt MD 20770			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 3, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850			25a DATE REC'D. BY REGISTRAR NOV 2 1987		
			25b REGISTRAR'S SIGNATURE T. Anderson-Randall		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR: Anna Marie Nootenboom 2a. DATE OF DEATH: MONTH <u>10</u> DAY <u>30</u> YEAR <u>1987</u> 2b. HOUR <u>1530 AM</u>										
1 DECEASED NAME (TYPE OR PRINT) ANNA MARIE NOOTENBOOM			3 SEX Female			4 RACE White		5 DATE OF BIRTH MONTH <u>July</u> DAY <u>31</u> YEAR <u>1901</u>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Derwood			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16211 Redland Road, 20855			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dental Assistant		12b KIND OF BUSINESS OR INDUSTRY Health Care		
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Derwood		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 16211 Redland Road 20855	
14 FATHER'S NAME FIRST Samuel MIDDLE Liesveld LAST Marie			15 MOTHER'S MAIDEN NAME FIRST Marie MIDDLE Van de Wege LAST Van de Wege							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 215-34-3011			17 INFORMANT Selma Nootenboom, Derwood, Md. 20855				
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause a, stating the underlying cause last b. <u>Diffuse Atherosclerotic Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF c. <u>Cotnam's Disease, Possible Pulmonary</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pulmonary Embolism, Hypertension, Polymyalgia Rheumatica</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) this hospital attended the deceased from <u>Nov 19 84</u> to <u>Present</u> 19 <u>87</u> that (2) we last saw the deceased alive on <u>10/26</u> 19 <u>87</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)										
22b SIGNATURE <u>Douglas R. Summer</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/30/87</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>DOUGLAS R. SUMMER, MD</u>						22e ADDRESS <u>615 W. MONTGOMERY AVE. ROCKVILLE, MD 20850</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Nov. 3, 1987		23c NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Darnestown Mont. Maryland			
24 FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md. 20879						25a DATE REC'D. BY REGISTRAR NOV 04 1987		25b REGISTRAR'S SIGNATURE <u>Julia D. Davidson-Randall</u>		

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

070002 NOV 20 1954

TO: DIRECTOR, FBI (100-371000) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO EUROPE.

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER TWENTY, FIFTYFOUR.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON OCTOBER TWENTY, FIFTYFOUR, JAMES EARL RAY, AKA, ADVISED THAT HE HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM A PASSPORT FOR TRIP TO EUROPE.

RAY STATED THAT HE HAD REFUSED THE OFFER AND WAS CURRENTLY ATTEMPTING TO OBTAIN A PASSPORT THROUGH THE NORMAL CHANNELS.

RAY STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL WHO OFFERED HIM THE PASSPORT WAS CURRENTLY ATTEMPTING TO OBTAIN A PASSPORT THROUGH THE NORMAL CHANNELS.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE T. O'BRIEN										2a. DATE KNOWN OF DEATH ESTIMATED X 10 25 19 87		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 29, 1929		6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YR MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 26 19 87		7d. HOUR 2:04 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5305 Sherrill Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist				12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>		13e. STREET ADDRESS 5305 Sherrill Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Meyers O'Brien						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Cudihy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1955-1957		17. INFORMANT Robert A.O'Brien				ADDRESS 5615 Lamar Rd. Beth.Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY 79289 IMMEDIATE CAUSE (a) Head trauma complicating acute ethanol intoxication and-chronic alcoholism.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUPLICATE TO, OR AS A CONSEQUENCE OF (b) chronic alcoholism.		
DUPLICATE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES X NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 25 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hit head	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5305 Sherrill Avenue, Chevy Chase, Montgomery Co., Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Charles P. Kokes		TITLE (SPECIFY) Assistant		DATE SIGNED 10-27-87	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		ADDRESS Washington, D.C.		25a. DATE RECD. BY REGISTRAR NOV 02 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME 15)

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10561-101-301

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Patrick C. O'Leary			2a DATE OF DEATH MONTH DAY YEAR 10 / 9 / 87		2b HOUR MIN 12 50 AM
3 SEX m	4 RACE C	5 DATE OF BIRTH MONTH DAY YEAR 2 02 11		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a BIRTHPLACE COUNTRY Montana	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b KIND OF BUSINESS OR INDUSTRY H.U.D.
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL O'LEARY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 216 44 4534		17 INFORMANT ADDRESS HILDA G. O'LEARY WIFE SAME AS 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN 4 mon					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OBSTRUCTIVE JAUNDICE					
19a DATE OF OPERATION 17 AUG 1987		19b CONDITION FOR WHICH OPERATION WAS PERFORMED PERITONITIS		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from AUG 4 19 87 to OCT 8 19 87 that (1) <input checked="" type="checkbox"/> last saw the deceased alive on OCT 8 19 87 and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b SIGNATURE Harold S. Tidler M.D.				22c DATE SIGNED 10/9/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD S. TIDLER, M.D.				22e ADDRESS 9801 GEORGIA AVENUE SILVER SPRING, MD.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT. 13, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE John Davidson	
500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901					

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OCT 14 1964

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG NO

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTI MATED	MONTH	DAY	YEAR	2b HOUR
Albert E. Ollison					X	10	31	1987	M
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d HOUR
Male	Blk	May 29, 1949	38 YRS.			10-31		1987	2:10 A.M.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina		USA				Montgomery County MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Correctional Spc Govt			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?				
13a STATE					13e STREET ADDRESS				
Maryland					6229 Auth Road 20746				
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Albert E. Ollison					Pearlie M. Grady				
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					17 INFORMANT ADDRESS				
Yes 4 Oct 67					Therese A. Ollison Suitland, MD				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY		
IMMEDIATE CAUSE (a) Thoraco-abdominal trauma		
DUE TO, OR AS A CONSEQUENCE OF		
(b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	12:30AM 10-31-87	Driver in auto/auto collision
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)	21f LOCATION
	road	Route 29 at Greencastle Road, Silver Spring, Montgomery County, MD

22a I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED	
	M.D. Deputy Chief	11-1-87	
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS		
Ann M. Dixon, M.D.	111 Penn Street, Baltimore, MD 21201		

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	Nov/5/87	Cheltenham	Cheltenham PG MD
24 FUNERAL DIRECTOR NAME	25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
E.M. Dudley	NOV 06 1987		
3200 Rhode Island Avenue Mt. Rainier, MD 20712			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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070358 OCT 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR
2- DECEASED NAME FIRST MIDDLE LAST MARIE OSCAR
3 SEX FEMALE 4 RACE WHITE 5 DATE OF BIRTH MONTH DAY YEAR April 1 1906 6 AGE (IN YEARS) (LAST BIRTHDAY) 81 YRS. 7a DATE KNOWN OF DEATH MONTH DAY YEAR Oct 22 1987 7b HOUR 10:30 P.M. 7c DATE PRONOUNCED DEAD MONTH DAY YEAR Oct 22 1987 7d HOUR 10:30 A.M. 7e BIRTHPLACE (STATE OR COUNTY) WASHINGTON, DC 7f CITIZEN OF WHAT COUNTRY? U. S. A. 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY 10 CITY OR TOWN OF DEATH Silver Spring 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp. 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE 12b KIND OF BUSINESS OR INDUSTRY OWN HOME 13a USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS BEFORE ADMISSION) MARYLAND MONTGOMERY SILVER SPRING 13b INSIDE CITY LIMITS? YES ☒ NO ☐ 13c STREET ADDRESS 20902 A 1121 Univ. Blvd. 14 FATHER'S NAME ABRAHAM MIDDLE ROSENFELD 15 MOTHER'S MAIDEN NAME (UNASCERTAINABLE) (UNASCERTAINABLE) 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b SOCIAL SECURITY NO. 220-48-8588 17 INFORMANT ADDRESS DR. ALVIN D. OSCAR, 5755 RIDGE AVENUE, PHILADELPHIA, PENN.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
888 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF
Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Fracture Rt. Hip
19a DATE OF OPERATION 9-11-87 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt. Hip 19c AUTOPSY? YES ☐ NO ☒ 20a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH 20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 26 1987 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fell at home of friend 20d INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ NOT AT WORK ☒ 20e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home 20f LOCATION (CITY OR TOWN, COUNTY, STATE) Mt. Pleasant S.I. Spg Mont. 21a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ 22a ACTUAL SIGNATURE (Signature) TITLE (SPECIFY) M.D. 22b MEDICAL EXAMINER'S NAME DR. JOHN S. ROGERS, M.D. 22c ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MARYLAND 22d DATE SIGNED Oct 22 1987

23a BURIAL, CREMATION, REMOVAL BURIAL 23b DATE 10/23/1987 23c NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY 23d LOCATION PRINCE GEORGES MARYLAND 24a FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 24b ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C. 25a DATE REC'D. BY REGISTRAR OCT 28 1987 25b REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 B4 25M

BP

DHMH - 17
(VR A15 ME (5))

70328 OCT 1967

20X6 COTTON 4858

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **B**, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

2a DECEASED NAME (PRINT OR TYPE) MICHAEL JOSEPH O'SHEA			2b DATE OF DEATH MONTH DAY YEAR OCT. 9 1987			2c HOUR 11:43 PM			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 8 21 05		6 AGE (IN YEARS LAST BIRTHDAY) 82		6a IF UNDER 1 YEAR MONTHS DAYS YRS	
7a BIRTHPLACE (COUNTRY) IRELAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b KIND OF BUSINESS OR INDUSTRY NATL CAR LOAD-ING CORP.			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1306 MORNINGSIDE DRIVE 20904	
14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL O'SHEA			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH BARRINGTON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 081-10-1292		17 INFORMANT ELIZABETH MCCARTHY/DAUGHTER/SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular cerebro DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 1984 19 10/9 19 87 that (I) (we) last saw the deceased alive on 10/9 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Joseph M. Solinas				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/9/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS				22e ADDRESS 9801 GEORGIA AVENUE SILVER SPRING, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 13, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		23d LOCATION (CITY OR TOWN) SILVER SPRING MONTGOMERY MD			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a DATE REC'D BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Rose			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901									

00700 011281

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]


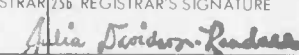
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonated copy of page 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows city, injury, or other traumatic event, the medical examiner must be notified at once.

DHMH = 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie E. Owens			2a DATE OF DEATH MONTH DAY YEAR 10 11 87		2b HOUR 10:34am	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR June 16, 1916		
6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7 UNDER 1 YEAR MONTHS DAYS 10 11		8 UNDER 24 HRS. HOURS MIN. 10 34		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY		13a STATE MD		
13b COUNTY Montg.		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Charles Moore, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Dorsey		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO. 215-20-3242		17 INFORMANT ADDRESS 8819 Tallyho Trail		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 RENAL FAILURE, DIABETES, Hypertension						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (E.g. HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from 12-21 , 19 82 , to 7-4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE 		DEGREE MD		22c DATE SIGNED 10/12/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joel L. Goozh, M.D.		22e ADDRESS 4701 Randolph Rd., Rockville, MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-16-87		23c NAME OF CEMETERY OR CREMATORY Rest Haven Mem. Gdns		
23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Fred., MD		24 FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850				
25a DATE RECD. BY REGISTRAR 19 1987		25b REGISTRAR'S SIGNATURE 				

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069482 OCT 20 1987

FILE # 6633 Item 1a, 2c 11/27/87
 1- STATE PART 2, 640 6-10-87
 REGISTRAR

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3007
 REG NO

1- DECEASED NAME (TYPE OR PRINT) Donald M. Owens		2a DATE KNOWN OF DEATH MONTH DAY YEAR 10/ 17/ 87		2b HOUR M P
3 SEX M	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 2 23 52	6 AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS.	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Tech
12b KIND OF BUSINESS OR INDUSTRY TNH		13a STATE Md.		
13b COUNTY Prince George		13c CITY OR TOWN Temple Hills	13d STREET ADDRESS 2301 Olson St. 20748	
14 FATHER'S NAME FIRST MIDDLE LAST Bernard L. White		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara C. Owens		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b SOCIAL SECURITY NO. 578 72 2319		17 INFORMANT ADDRESS 20748 Barbara C. Owens 2301 Olson St.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I HIV Antibody positive				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f EDUCATION (SCHOOL) CITY OR TOWN COUNTY STATE
22. I certify that I took charge of the remains described above, field on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Dennis F. Smyth		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 10/20/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/24/87	23c NAME OF CEMETERY OR CREMATORY Harmony	23d LOCATION CITY OR TOWN COUNTY STATE Landover, Md.	
24 FUNERAL DIRECTOR NAME James A. Morton & Sons 1701 Laurens St.		25a DATE REC'D. BY REGISTRAR OCT 21 1987		
25b REGISTRAR'S SIGNATURE Julia Davidson-Randall				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

AMALIA

PADILLA

2a. DATE OF DEATH

MONTH

DAY

YEAR

OCT. 28, 1987

2b. HOUR

8:50 PM

3 SEX

FEMALE

4 RACE

C

5 DATE OF BIRTH

MONTH

DAY

YEAR

JULY 14, 1903

6 AGE (IN YEARS (LAST BIRTHDAY))

84

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

PUERTO RICO

7b CITIZEN OF WHAT COUNTRY?

8

MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD

10 CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SUBURBAN HOSPITAL

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

HOMEMAKER

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

MONTGOMERY

13c CITY OR TOWN

BETHESDA

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

8702 IRVINGTON AVENUE 20817

14 FATHER'S NAME

JOSE

MIDDLE

ANICETO

LAST

PABON

15 MOTHER'S MAIDEN NAME

GREGORIA

MIDDLE

LAST

FIGUEROA

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

058-24-6716

17 INFORMANT

DAUGHTER

ADDRESS

NORA FITZPATRICK/SAME AS 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Acute Cardio Pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Septicemia Acute & Chronic

DUE TO, OR AS A CONSEQUENCE OF

Impaired cerebral circulation according

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I (a) OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 10/28/87 19 87 to 10/28/87 19 87 that (I) (we) last saw the deceased alive on 10/28/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

22c DATE SIGNED

10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

FRANCIS J. COLLINS, JR.

22e ADDRESS

20428 Germantown Rd

Germantown, MD 20876

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b DATE

OCT 31, 1987

23c NAME OF CEMETERY OR CREMATORY

GATE OF HEAVEN CEMETERY SILVER SPRING MONTGOMERY MD

23d LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME FRANCIS J. COLLINS, JR.

25a DATE REC'D BY REGISTRAR

NOV 06 1987

25b REGISTRAR'S SIGNATURE

K. J. Collins

500 UNIVERSITY BLVD W SILVER SPRING, MD 20901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and Registrar, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15115 NOV-03

15115
NOV-03

NOV 03 15115

GY
068320 OCT 13 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) SHEILA MARY PADULA					2a DATE OF DEATH OCTOBER 5, 1987			2b HOUR 11:15PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH JUNE 29 1938		6 AGE (IN YEARS LAST BIRTHDAY) 49 YRS		IF UNDER 1 YEAR MONTH DAY HOUR MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MASSACHUSETTS 13b COUNTY Norfolk 13c CITY OR TOWN FRANKLIN					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 3 Lincolnwood Dr. 02038		
14 FATHER'S NAME William Spadoni					15 MOTHER'S MAIDEN NAME Margaret Logan				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 020 30 0670		17 INFORMANT JOHN R. PADULA, HUSBAND			ADDRESS (SAME)		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPOTENSION AND HYPOXEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MUCORMYCOSES DUE TO, OR AS A CONSEQUENCE OF (c) 5 q MYELODYSPLASTIC SYNDROME									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WEEK 7 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)					
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from SEPTEMBER 15, 19 87 to OCTOBER 5, 19 87 that (we) last saw the deceased alive on OCTOBER 5, 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (did not) view the body after death.									
22b SIGNATURE Alan G.D. Hoffman, MD					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Oct 6, 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALAN G.D. HOFFMAN					22e ADDRESS NATIONAL INSTITUTES OF HEALTH 9000 ROCKVILLE PIKE, BETHESDA, MD. 20892				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct 10 1987		23c NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d LOCATION Franklin, Mass.			
24 FUNERAL DIRECTOR NAME Ives-Pearson F. H. Arlington, Va. 22201					25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE John Davidson-Randall		

BP

068350 OCT 1961

10/25/61 100-1-3035

10/25/61

Rev. G. D. Hoffman, MD
Attn: G. D. Hoffman

10/25/61 100-1-3035

069540 OCT 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30074

1 DECEASED NAME (TYPE OR PRINT) Leonard W. Page				2a DATE KNOWN OF DEATH MONTH 10 DAY 15 YEAR 1987				2b HOUR 4:50 M P	
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH 2 DAY 29 YEAR 1959	6 AGE (IN YEARS) YEARS 28	IF UNDER 1 YR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	7c DATE PRONOUNCED DEAD MONTH 10 DAY 15 YEAR 1987		2d HOUR 4:50 M P	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a USUAL OCCUPATION (TYPE OF WORK) Unemployed		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.				13b COUNTY Montg.		13c CITY OR TOWN Bermantown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Henry R. MIDDLE PAGE LAST PAGE				15 MOTHER'S MAIDEN NAME FIRST HANNAH F. MIDDLE BASIL LAST BASIL					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. 229-34-6703		17 INFORMANT Henry W. PAGE (Bro.) ADDRESS SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive Pulmonary Disease									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John J. Tanber		TITLE (SPECIFY) Deputy		M.D. Deputy		MEDICAL EXAMINER Deputy		DATE SIGNED 10-16-87	
EXAMINER'S NAME (TYPE OR PRINT) John J. Tanber		ADDRESS 3218 Wisconsin Ave							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-22-87		23c NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Round Hill, Virginia			
24 FUNERAL DIRECTOR NAME George R. Snowden				ADDRESS Rockville, MD 20850		25a DATE REC'D. BY REGISTRAR 10-19-87		25b REGISTRAR'S SIGNATURE John J. Tanber	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH 17
(VR A15 ME (5))

069328 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BARBARA J. PANIZARI			2a DATE OF DEATH MONTH DAY YEAR 10-17-87		2b HOUR 2 45 PM
3 SEX Female	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR 2-13-1933		6 AGE (IN YEARS LAST BIRTHDAY) 54	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Clerk	12b KIND OF BUSINESS OR INDUSTRY private	
13a STATE MD		13b CITY OR TOWN Beltsville	13c STREET ADDRESS / ZIP CODE 3607 Dunnington Rd. 20705		
14 FATHER'S NAME (FIRST MIDDLE LAST) Bartholameu Thorngerg		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Julia Medak			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 044-24-9563	17 INFORMANT ADDRESS Joseph Panizari same as 13e. above		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>CHRONIC COR PULMONALE</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>ANTERIOR Myocardial Infarction - Congestive Heart Failure (CPD).</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION (STREET CITY COUNTY STATE)	
22a I certify that (1) this hospital attended the deceased from <u>2/87</u> 19 to <u>present</u> 19 that (2) we lost saw the deceased alive on <u>10/15</u> 19 <u>87</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)					
22b SIGNATURE <u>Peter Tanna, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/17/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER TANNA, M.D., PhD.		22e ADDRESS 12708 SERPENTINE SILVER SPRING MD 20904			
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 10-20-87	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d LOCATION (CITY OR TOWN COUNTY STATE) Silver Spring Mont. Md.
24 FUNERAL DIRECTOR Donald V. Borgwardt		4400 Powder Mill Road Beltsville, Maryland 20705		25a DATE REC'D. BY REGISTRAR OCT 20 1987	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by Dr. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

68549 OCT 14

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MARIA		MIDDLE PAPASPYROPOULOS		2a DATE KNOWN OF DEATH ESTIMATED MONTH 08 DAY 10 YEAR 1987		2b HOUR 3:45	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH June DAY 20 YEAR 1903	6 AGE (IN YEARS) LAST BIRTHDAY YRS. 84	7c DATE PRONOUNCED DEAD MONTH 08 DAY 10 YEAR 1987	7d HOUR 3:45		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Romania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> XXXXXXXXXX		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Tak Park		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lincoln Advent. Hosp		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own car	
13a STATE MD		13b COUNTY Monte		13c CITY OR TOWN Tak Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Bukur MIDDLE Mardale LAST Mardale		15 MOTHER'S MAIDEN NAME FIRST unobtainable MIDDLE unobtainable LAST unobtainable		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES) N/A (UNKNOWN) N/A (IF N/A WAR OR DATES)			
16b SOCIAL SECURITY NO. 213-38-0466		17 INFORMANT ADDRESS George Papaspyropoulos-husband-(same as 13c)					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that I took charge of the remains described above, held on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE **John S. Rogers, DME** TITLE (SPECIFY) **MD** MEDICAL EXAMINER DATE SIGNED **08/10/1987**
EXAMINER'S NAME (TYPE OR PRINT) **John S. Rogers, DME** ADDRESS **1919 Seminary Rd. S.S. Md.**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-12-87	23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d LOCATION CITY OR TOWN Washington, DC
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.H. ave., Silver Spring, Md.		25a DATE REC'D. BY REGISTRAR OCT 13 1987	25b REGISTRAR'S SIGNATURE John S. Rogers

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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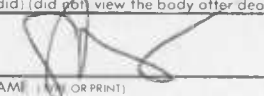
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH


REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph P. PARLON, JR.			2a. DATE OF DEATH MONTH DAY YEAR 10-22-87		2b. HOUR 8 AM		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 7 31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Scholar Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SPEC. AGENT		12b. KIND OF BUSINESS OR INDUSTRY D.E. ADMIN	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH PATRICK PARLON, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DAY		13e. STREET ADDRESS / ZIP CODE 13123 BEAVER TERRACE 20853			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1954		17. INFORMANT ADDRESS PATRICIA C. PARLON/WIFE/SAME AS 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-pulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
DUE TO, OR AS A CONSEQUENCE OF (b) hepatic CIRRHOSIS		5 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 19 87 to October 19 87 , that (I) (we) last saw the deceased alive on October 21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Vaccarezza				22e. ADDRESS 6246 Montrose Rd Rockville Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT 26, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a. DATE REC'D BY REGISTRAR OCT 29 1987		25b. REGISTRAR'S SIGNATURE 	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) DAVID NMI PEARL			2a DATE OF DEATH MONTH 10 DAY 15 YEAR 87		2b HOUR 9:45 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH Jan. DAY 27 YEAR 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTH YRS. DAY YRS. HOUR MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Owner (Ret.)		12b KIND OF BUSINESS OR INDUSTRY Shoe
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST JULIUS MIDDLE PEARL LAST PEARL			15 MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE (Unknown) LAST (Unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 044-07-9365		17 INFORMANT Jack Pearl; Son; 14413 Bauer Drive; Rockville, Md. 20853	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (1) PNEUMONIA (2) DIABETES (3) RENAL FAILURE			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 21B, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION CITY OR TOWN Rockville COUNTY Montgomery STATE MD	
22 I certify that (I) (this hospital) attended the deceased from 10/15/87 to 10/15/87 , that (I) (we) last saw the deceased alive on 10/15/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a SIGNATURE R. C. Daddario	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/16/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. DADDARIO		22e ADDRESS 5413 CEDAR LANE BETHESDA, MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 10/19/87	23c NAME OF CEMETERY OR CREMATORY Lee Crematory	23d LOCATION CITY OR TOWN Washington, D.C. COUNTY D.C. STATE D.C.
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852		25 DATE RECEIVED BY REGISTRAR OCT 21 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Evelyn NMI Pemberton			2a. DATE OF DEATH MONTH DAY YEAR 10-9-87		2b. HOUR 7:50 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 29 66		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Gov't VA	
13a. STATE Md.			13b. COUNTY MONT	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Alexander D. Watson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-16-6075	17. INFORMANT ADDRESS Mr. Clyde A. Gray/son/606 Potomac Valley Dr. Ft. Wash., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Broncho pneumonia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-9-87</u> to <u>10-9-87</u> that (I) (we) last saw the deceased alive on <u>10-9-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Tauber		DEGREE MD		22c. DATE SIGNED 10-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8218 Wisconsin Ave. Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10-14-87	23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Md.	
24. FUNERAL DIRECTOR NAME John T. Rhines Co., 3015 12th St. N.E., D.C. 20017			25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE Julia Swider-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 0 0 8 1

1 - FOR
STATE
REGISTRAR

2a DECEASED NAME (TYPE OR PRINT) ANN POLLACK			2b DATE OF DEATH MONTH DAY YEAR OCTOBER 29 1987			2c HOUR 7:45 P.M.		
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH DECEMBER 18, 1899		
6 AGE (IN YEARS (LAST BIRTHDAY)) 87			7a BIRTHPLACE (STATE OR FOREIGN) NEW YORK			7b CITIZEN OF WHAT COUNTRY? U. S. A.		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10 CITY OR TOWN OF DEATH WHEATON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MANOR CARE NURSING HOME			12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOUSEWIFE		
12b KIND OF BUSINESS OR INDUSTRY OWN HOME			13a STREET ADDRESS / ZIP CODE 280 SIERRA DRIVE - FLORIDA 33179					
13b USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) FLORIDA			13c CITY OR TOWN DADE MIAMI			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME ISAAC			15 MOTHER'S MAIDEN NAME REBECCA (UNASCERTAINABLE)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO. 076-26-2688			17 INFORMANT ARLENE MILLER, 4410 ROSEDALE AVENUE, BETHESDA, MARYLAND		
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from <u>8/18</u> 19 <u>87</u> to <u>10/30</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10/30</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) and (did not) view the body after death.								
22b SIGNATURE <u>Myron L. Lenkin</u>			DEGREE			22c DATE SIGNED <u>10/30/87</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. MYRON L. LENKIN, M. D.			22e ADDRESS 2309 SHOREFIELD ROAD WHEATON, MARYLAND					
23a BURIAL, CREMATION, REMOVAL BURIAL			23b DATE 11/1/1987			23c NAME OF CEMETERY OR CREMATORY BETH ISRAEL CEMETERY		
23d LOCATION CITY OR TOWN COUNTY STATE WOODBIDGE, NEW JERSEY								
24 DONOR OF ORGAN OR TISSUE DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			25a DATE REC'D BY REGISTRAR NOV 02 1987			25b REGISTRAR'S SIGNATURE <u>John Davidson</u>		

071001-100170

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068710 OCT 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Vivian L. Pollack					ESTI. MATED		10	10	1987	123 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
F	C	MONTH DAY YEAR		LAST BIRTHDAY	MONTHS DAYS HOURS MIN				MONTH DAY YEAR		
		6 2 07		80 YRS					10 10 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Wash. DC		USA					Montgomery MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				SUPERV. OF OPERATORS		Tel 6			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md				Prince George's		Beltsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		20705	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
GEORGE F. LENZ				MARY E. COLLINS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				577-01-1613		ROBERT J. POLLACK, SR./HUSBAND/SAME AS 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <u>Fracture Hip</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7888		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		
None		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
2-26-87	Fracture Hip	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 225 1987	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (A) HOME, STREET FACTORY, FARM, ETC.) Street	21f. LOCATION CITY OR TOWN COUNTY STATE Beltsville Prince Georges Md

22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) M.D. <u>Doc</u> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS		DATE SIGNED <u>Oct 10 1987</u>	
ADDRESS SEMINARY ROAD SILVER SPRING, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	OCT13, 1987	CEDAR HILL CEMETERY	SUITLAND PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		OCT 14 1987	<u>John Davidson-Randall</u>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

DMH-17
(VR A15 ME (5))
15M7/77

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

000710 OCT 1987

[Faint, illegible handwritten text covering the majority of the page]

000710 OCT 1987

Sent
12/7/87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The information on this certificate is to be furnished to the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. 3-5-7-9-11-13-15-17-19-21-23-25-27-29-31-33-35-37-39-41-43-45-47-49-51-53-55-57-59-61-63-65-67-69-71-73-75-77-79-81-83-85-87-89-91-93-95-97-99-101-103-105-107-109-111-113-115-117-119-121-123-125-127-129-131-133-135-137-139-141-143-145-147-149-151-153-155-157-159-161-163-165-167-169-171-173-175-177-179-181-183-185-187-189-191-193-195-197-199-201-203-205-207-209-211-213-215-217-219-221-223-225-227-229-231-233-235-237-239-241-243-245-247-249-251-253-255-257-259-261-263-265-267-269-271-273-275-277-279-281-283-285-287-289-291-293-295-297-299-301-303-305-307-309-311-313-315-317-319-321-323-325-327-329-331-333-335-337-339-341-343-345-347-349-351-353-355-357-359-361-363-365-367-369-371-373-375-377-379-381-383-385-387-389-391-393-395-397-399-401-403-405-407-409-411-413-415-417-419-421-423-425-427-429-431-433-435-437-439-441-443-445-447-449-451-453-455-457-459-461-463-465-467-469-471-473-475-477-479-481-483-485-487-489-491-493-495-497-499-501-503-505-507-509-511-513-515-517-519-521-523-525-527-529-531-533-535-537-539-541-543-545-547-549-551-553-555-557-559-561-563-565-567-569-571-573-575-577-579-581-583-585-587-589-591-593-595-597-599-601-603-605-607-609-611-613-615-617-619-621-623-625-627-629-631-633-635-637-639-641-643-645-647-649-651-653-655-657-659-661-663-665-667-669-671-673-675-677-679-681-683-685-687-689-691-693-695-697-699-701-703-705-707-709-711-713-715-717-719-721-723-725-727-729-731-733-735-737-739-741-743-745-747-749-751-753-755-757-759-761-763-765-767-769-771-773-775-777-779-781-783-785-787-789-791-793-795-797-799-801-803-805-807-809-811-813-815-817-819-821-823-825-827-829-831-833-835-837-839-841-843-845-847-849-851-853-855-857-859-861-863-865-867-869-871-873-875-877-879-881-883-885-887-889-891-893-895-897-899-901-903-905-907-909-911-913-915-917-919-921-923-925-927-929-931-933-935-937-939-941-943-945-947-949-951-953-955-957-959-961-963-965-967-969-971-973-975-977-979-981-983-985-987-989-991-993-995-997-999-1001-1003-1005-1007-1009-1011-1013-1015-1017-1019-1021-1023-1025-1027-1029-1031-1033-1035-1037-1039-1041-1043-1045-1047-1049-1051-1053-1055-1057-1059-1061-1063-1065-1067-1069-1071-1073-1075-1077-1079-1081-1083-1085-1087-1089-1091-1093-1095-1097-1099-1101-1103-1105-1107-1109-1111-1113-1115-1117-1119-1121-1123-1125-1127-1129-1131-1133-1135-1137-1139-1141-1143-1145-1147-1149-1151-1153-1155-1157-1159-1161-1163-1165-1167-1169-1171-1173-1175-1177-1179-1181-1183-1185-1187-1189-1191-1193-1195-1197-1199-1201-1203-1205-1207-1209-1211-1213-1215-1217-1219-1221-1223-1225-1227-1229-1231-1233-1235-1237-1239-1241-1243-1245-1247-1249-1251-1253-1255-1257-1259-1261-1263-1265-1267-1269-1271-1273-1275-1277-1279-1281-1283-1285-1287-1289-1291-1293-1295-1297-1299-1301-1303-1305-1307-1309-1311-1313-1315-1317-1319-1321-1323-1325-1327-1329-1331-1333-1335-1337-1339-1341-1343-1345-1347-1349-1351-1353-1355-1357-1359-1361-1363-1365-1367-1369-1371-1373-1375-1377-1379-1381-1383-1385-1387-1389-1391-1393-1395-1397-1399-1401-1403-1405-1407-1409-1411-1413-1415-1417-1419-1421-1423-1425-1427-1429-1431-1433-1435-1437-1439-1441-1443-1445-1447-1449-1451-1453-1455-1457-1459-1461-1463-1465-1467-1469-1471-1473-1475-1477-1479-1481-1483-1485-1487-1489-1491-1493-1495-1497-1499-1501-1503-1505-1507-1509-1511-1513-1515-1517-1519-1521-1523-1525-1527-1529-1531-1533-1535-1537-1539-1541-1543-1545-1547-1549-1551-1553-1555-1557-1559-1561-1563-1565-1567-1569-1571-1573-1575-1577-1579-1581-1583-1585-1587-1589-1591-1593-1595-1597-1599-1601-1603-1605-1607-1609-1611-1613-1615-1617-1619-1621-1623-1625-1627-1629-1631-1633-1635-1637-1639-1641-1643-1645-1647-1649-1651-1653-1655-1657-1659-1661-1663-1665-1667-1669-1671-1673-1675-1677-1679-1681-1683-1685-1687-1689-1691-1693-1695-1697-1699-1701-1703-1705-1707-1709-1711-1713-1715-1717-1719-1721-1723-1725-1727-1729-1731-1733-1735-1737-1739-1741-1743-1745-1747-1749-1751-1753-1755-1757-1759-1761-1763-1765-1767-1769-1771-1773-1775-1777-1779-1781-1783-1785-1787-1789-1791-1793-1795-1797-1799-1801-1803-1805-1807-1809-1811-1813-1815-1817-1819-1821-1823-1825-1827-1829-1831-1833-1835-1837-1839-1841-1843-1845-1847-1849-1851-1853-1855-1857-1859-1861-1863-1865-1867-1869-1871-1873-1875-1877-1879-1881-1883-1885-1887-1889-1891-1893-1895-1897-1899-1901-1903-1905-1907-1909-1911-1913-1915-1917-1919-1921-1923-1925-1927-1929-1931-1933-1935-1937-1939-1941-1943-1945-1947-1949-1951-1953-1955-1957-1959-1961-1963-1965-1967-1969-1971-1973-1975-1977-1979-1981-1983-1985-1987-1989-1991-1993-1995-1997-1999-2001-2003-2005-2007-2009-2011-2013-2015-2017-2019-2021-2023-2025-2027-2029-2031-2033-2035-2037-2039-2041-2043-2045-2047-2049-2051-2053-2055-2057-2059-2061-2063-2065-2067-2069-2071-2073-2075-2077-2079-2081-2083-2085-2087-2089-2091-2093-2095-2097-2099-2101-2103-2105-2107-2109-2111-2113-2115-2117-2119-2121-2123-2125-2127-2129-2131-2133-2135-2137-2139-2141-2143-2145-2147-2149-2151-2153-2155-2157-2159-2161-2163-2165-2167-2169-2171-2173-2175-2177-2179-2181-2183-2185-2187-2189-2191-2193-2195-2197-2199-2201-2203-2205-2207-2209-2211-2213-2215-2217-2219-2221-2223-2225-2227-2229-2231-2233-2235-2237-2239-2241-2243-2245-2247-2249-2251-2253-2255-2257-2259-2261-2263-2265-2267-2269-2271-2273-2275-2277-2279-2281-2283-2285-2287-2289-2291-2293-2295-2297-2299-2301-2303-2305-2307-2309-2311-2313-2315-2317-2319-2321-2323-2325-2327-2329-2331-2333-2335-2337-2339-2341-2343-2345-2347-2349-2351-2353-2355-2357-2359-2361-2363-2365-2367-2369-2371-2373-2375-2377-2379-2381-2383-2385-2387-2389-2391-2393-2395-2397-2399-2401-2403-2405-2407-2409-2411-2413-2415-2417-2419-2421-2423-2425-2427-2429-2431-2433-2435-2437-2439-2441-2443-2445-2447-2449-2451-2453-2455-2457-2459-2461-2463-2465-2467-2469-2471-2473-2475-2477-2479-2481-2483-2485-2487-2489-2491-2493-2495-2497-2499-2501-2503-2505-2507-2509-2511-2513-2515-2517-2519-2521-2523-2525-2527-2529-2531-2533-2535-2537-2539-2541-2543-2545-2547-2549-2551-2553-2555-2557-2559-2561-2563-2565-2567-2569-2571-2573-2575-2577-2579-2581-2583-2585-2587-2589-2591-2593-2595-2597-2599-2601-2603-2605-2607-2609-2611-2613-2615-2617-2619-2621-2623-2625-2627-2629-2631-2633-2635-2637-2639-2641-2643-2645-2647-2649-2651-2653-2655-2657-2659-2661-2663-2665-2667-2669-2671-2673-2675-2677-2679-2681-2683-2685-2687-2689-2691-2693-2695-2697-2699-2701-2703-2705-2707-2709-2711-2713-2715-2717-2719-2721-2723-2725-2727-2729-2731-2733-2735-2737-2739-2741-2743-2745-2747-2749-2751-2753-2755-2757-2759-2761-2763-2765-2767-2769-2771-2773-2775-2777-2779-2781-2783-2785-2787-2789-2791-2793-2795-2797-2799-2801-2803-2805-2807-2809-2811-2813-2815-2817-2819-2821-2823-2825-2827-2829-2831-2833-2835-2837-2839-2841-2843-2845-2847-2849-2851-2853-2855-2857-2859-2861-2863-2865-2867-2869-2871-2873-2875-2877-2879-2881-2883-2885-2887-2889-2891-2893-2895-2897-2899-2901-2903-2905-2907-2909-2911-2913-2915-2917-2919-2921-2923-2925-2927-2929-2931-2933-2935-2937-2939-2941-2943-2945-2947-2949-2951-2953-2955-2957-2959-2961-2963-2965-2967-2969-2971-2973-2975-2977-2979-2981-2983-2985-2987-2989-2991-2993-2995-2997-2999-3001-3003-3005-3007-3009-3011-3013-3015-3017-3019-3021-3023-3025-3027-3029-3031-3033-3035-3037-3039-3041-3043-3045-3047-3049-3051-3053-3055-3057-3059-3061-3063-3065-3067-3069-3071-3073-3075-3077-3079-3081-3083-3085-3087-3089-3091-3093-3095-3097-3099-3101-3103-3105-3107-3109-3111-3113-3115-3117-3119-3121-3123-3125-3127-3129-3131-3133-3135-3137-3139-3141-3143-3145-3147-3149-3151-3153-3155-3157-3159-3161-3163-3165-3167-3169-3171-3173-3175-3177-3179-3181-3183-3185-3187-3189-3191-3193-3195-3197-3199-3201-3203-3205-3207-3209-3211-3213-3215-3217-3219-3221-3223-3225-3227-3229-3231-3233-3235-3237-3239-3241-3243-3245-3247-3249-3251-3253-3255-3257-3259-3261-3263-3265-3267-3269-3271-3273-3275-3277-3279-3281-3283-3285-3287-3289-3291-3293-3295-3297-3299-3301-3303-3305-3307-3309-3311-3313-3315-3317-3319-3321-3323-3325-3327-3329-3331-3333-3335-3337-3339-3341-3343-3345-3347-3349-3351-3353-3355-3357-3359-3361-3363-3365-3367-3369-3371-3373-3375-3377-3379-3381-3383-3385-3387-3389-3391-3393-3395-3397-3399-3401-3403-3405-3407-3409-3411-3413-3415-3417-3419-3421-3423-3425-3427-3429-3431-3433-3435-3437-3439-3441-3443-3445-3447-3449-3451-3453-3455-3457-3459-3461-3463-3465-3467-3469-3471-3473-3475-3477-3479-3481-3483-3485-3487-3489-3491-3493-3495-3497-3499-3501-3503-3505-3507-3509-3511-3513-3515-3517-3519-3521-3523-3525-3527-3529-3531-3533-3535-3537-3539-3541-3543-3545-3547-3549-3551-3553-3555-3557-3559-3561-3563-3565-3567-3569-3571-3573-3575-3577-3579-3581-3583-3585-3587-3589-3591-3593-3595-3597-3599-3601-3603-3605-3607-3609-3611-3613-3615-3617-3619-3621-3623-3625-3627-3629-3631-3633-3635-3637-3639-3641-3643-3645-3647-3649-3651-3653-3655-3657-3659-3661-3663-3665-3667-3669-3671-3673-3675-3677-3679-3681-3683-3685-3687-3689-3691-3693-3695-3697-3699-3701-3703-3705-3707-3709-3711-3713-3715-3717-3719-3721-3723-3725-3727-3729-3731-3733-3735-3737-3739-3741-3743-3745-3747-3749-3751-3753-3755-3757-3759-3761-3763-3765-3767-3769-3771-3773-3775-3777-3779-3781-3783-3785-3787-3789-3791-3793-3795-3797-3799-3801-3803-3805-3807-3809-3811-3813-3815-3817-3819-3821-3823-3825-3827-3829-3831-3833-3835-3837-3839-3841-3843-3845-3847-3849-3851-3853-3855-3857-3859-3861-3863-3865-3867-3869-3871-3873-3875-3877-3879-3881-3883-3885-3887-3889-3891-3893-3895-3897-3899-3901-3903-3905-3907-3909-3911-3913-3915-3917-3919-3921-3923-3925-3927-3929-3931-3933-3935-3937-3939-3941-3943-3945-3947-3949-3951-3953-3955-3957-3959-3961-3963-3965-3967-3969-3971-3973-3975-3977-3979-3981-3983-3985-3987-3989-3991-3993-3995-3997-3999-4001-4003-4005-4007-4009-4011-4013-4015-4017-4019-4021-4023-4025-4027-4029-4031-4033-4035-4037-4039-4041-4043-4045-4047-4049-4051-4053-4055-4057-4059-4061-4063-4065-4067-4069-4071-4073-4075-4077-4079-4081-4083-4085-4087-4089-4091-4093-4095-4097-4099-4101-4103-4105-4107-4109-4111-4113-4115-4117-4119-4121-4123-4125-4127-4129-4131-4133-4135-4137-4139-4141-4143-4145-4147-4149-4151-4153-4155-4157-4159-4161-4163-4165-4167-4169-4171-4173-4175-4177-4179-4181-4183-4185-4187-4189-4191-4193-4195-4197-4199-4201-4203-4205-4207-4209-4211-4213-4215-4217-4219-4221-4223-4225-4227-4229-4231-4233-4235-4237-4239-4241-4243-4245-4247-4249-4251-4253-4255-4257-4259-4261-4263-4265-4267-4269-4271-4273-4275-4277-4279-4281-4283-4285-4287-4289-4291-4293-4295-4297-4299-4301-4303-4305-4307-4309-4311-4313-4315-4317-4319-4321-4323-4325-4327-4329-4331-4333-4335-4337-4339-4341-4343-4345-4347-4349-4351-4353-4355-4357-4359-4361-4363-4365-4367-4369-4371-4373-4375-4377-4379-4381-4383-4385-4387-4389-4391-4393-4395-4397-4399-4401-4403-4405-4407-4409-4411-4413-4415-4417-4419-4421-4423-4425-4427-4429-4431-4433-4435-4437-4439-4441-4443-4445-4447-4449-4451-4453-4455-4457-4459-4461-4463-4465-4467-4469-4471-4473-4475-4477-4479-4481-4483-4485-4487-4489-4491-4493-4495-4497-4499-4501-4503-4505-4507-4509-4511-4513-4515-4517-4519-4521-4523-4525-4527-4529-4531-4533-4535-4537-4539-4541-4543-4545-4547-4549-4551-4553-4555-4557-4559-4561-4563-4565-4567-4569-4571-4573-4575-4577-4579-4581-4583-4585-4587-4589-4591-4593-4595-4597-4599-4601-4603-4605-4607-4609-4611-4613-4615-4617-4619-4621-4623-4625-4627-4629-4631-4633-4635-4637-4639-4641-4643-4645-4647-4649-4651-4653-4655-4657-4659-4661-4663-4665-4667-4669-4671-4673-4675-4677-4679-4681-4683-4685-4687-4689-4691-4693-4695-4697-4699-4701-4703-4705-4707-4709-4711-4713-4715-4717-4719-4721-4723-4725-4727-4729-4731-4733-4735-4737-4739-4741-4743-4745-4747-4749-4751-4753-4755-4757-4759-4761-4763-4765-4767-4769-4771-4773-4775-4777-4779-4781-4783-4785-4787-4789-4791-4793-4795-4797-4799-4801-4803-4805-4807-4809-4811-4813-4815-4817-4819-4821-4823-4825-4827-4829-4831-4833-4835-4837-4839-4841-4843-4845-4847-4849-4851-4853-4855-4857-4859-4861-4863-4865-4867-4869-4871-4873-4875-4877-4879-4881-4883-4885-4887-4889-4891-4893-4895-4897-4899-4901-4903-4905-4907-4909-4911-4913-4915-4917-4919-4921-4923-4925-4927-4929-4931-4933-4935-4937-4939-4941-4943-4945-4947-4949-4951-4953-4955-4957-4959-4961-4963-4965-4967-4969-4971-4973-4975-4977-4979-4981-4983-4985-4987-4989-4991-4993-4995-4997-4999-5001-5003-5005-5007-5009-5011-5013-5015-5017-5019-5021-5023-5025-5027-5029-5031-5033-5035-5037-5039-5041-5043-5045-5047-5049-5051-5053-5055-5057-5059-5061-5063-5065-5067-5069-5071-5073-5075-5077-507

7155-101-301

069888 OCT 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH			X MONTH DAY YEAR HOUR		
Karen Ruth Porter						10 15 19 87			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	IF UNDER 1 YR	IF UNDER 24 HRS	7c DATE PRONOUNCED DEAD			2d HOUR		
Female	Caucasian	Jan. 24, 1957	30 YRS.			10 15 19 87			5:15P M		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		United States				Montgomery County MD					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Kensington		4514 Clearbrook Lane				Licensed Practical Nursing					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Maryland		Montgomery		Kensington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4514 Clearbrook Lane/ 20895			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Brent Alexander Fulcher				Flonnie Grace Williams							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT (Husband)		ADDRESS			
No				229-90-1687		Robert G. Porter		Same as line #13.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Seizure disorder											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i> (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/16/87											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St. Balto.MD.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Cremation		Oct. 16, 1987		Montgomery Crematorium		Bethesda				Maryland	
24 FUNERAL DIRECTOR Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc.						25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
7557 Wisconsin Ave. Bethesda, Maryland						OCT 26 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 4 AND 5 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Item 18a, 20, 21a, b, c, d, e, f, 22a, 6632 dw 3 0 0 8 5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR			2b HOUR				
Floyd Powell			9-24-1987			M				
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c DATE PRONOUNCED DEAD	7d HOUR			
Male	Black	Dec. 26, 1957	29 YRS.			9-24-1987	6:15 PM			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		9 BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Montgomery County		MD			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Spencerville		16701 Brogden Road (rear)(auto)			Truck Driver					
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS					
MD		Howard	Sykesville	YES <input type="checkbox"/> NO <input type="checkbox"/>	1350 Route 97/ 21784					
14 M. FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Walter F. Powell			Martha Ellison							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No			220-74-7101		Linda Powell 15704 Thompson Rd. Silver Spring, MD 20904					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide intoxication 8682 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-24 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject inhaled auto exhaust fumes					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Car		21f LOCATION STREET CITY OR TOWN COUNTY STATE 16701 Brogden Road, Spencerville, Montgomery, MD.					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							
Charles P. Kokes, M.D.			111 Penn Street, Baltimore, MD 21201							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Burial			10-3-87		Daisy Cemetery		Daisy, Howard Co., Md.			
24 FUNERAL DIRECTOR NAME ADDRESS			25a DATE REC'D. BY REGISTRAR						25b REGISTRAR'S SIGNATURE	
George R. Snowden Rockville, MD 20850			OCT 02 1987						[Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LaShaun Jamice Proctor			7a DATE OF DEATH MONTH DAY YEAR 10 05 87			7b HOUR 7:30 AM			
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 10 05 87		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 3 1 18		6 UNDER 1 YEAR MONTHS DAYS HOURS MIN 3 1 18	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b KIND OF BUSINESS OR INDUSTRY N/A			
13a STATE Maryland		13b COUNTY P.G.		13c CITY OR TOWN Marlboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 10707 Mt. Ludentia 20772	
14 FATHER'S NAME FIRST MIDDLE LAST James A Proctor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah THOMAS		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) —					
16b SOCIAL SECURITY NO —		17 INFORMANT ADDRESS Deborah T. Proctor(mother) same as 13e							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Hypoplasia DUE TO, OR AS A CONSEQUENCE OF (c) Renal Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 5 Oct 1987 to 5 Oct 1987 that (I) (we) last saw the deceased alive on 5 Oct 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Kenneth M Huttner				DEGREE M.D.		22c DATE SIGNED 5 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth M Huttner				22e ADDRESS 1500 Forest Glen Road S. S. Md 20910			

23a BURIAL, CREMATION, REMOVAL (SPEC) Burial		23b DATE 10/13/87		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a DATE REC'D BY REGISTRAR OCT 14 1987		25b REGISTRAR'S SIGNATURE Julia B. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

1271 751 350 380

01/01/2019 10:00 AM, 1/1/2019

069200 OCT 20-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Margaret C. Prosise			2a DATE OF DEATH MONTH DAY YEAR 10 10 87			2b HOUR 10 55 AM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 21 07		6 AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 2 YEARS MONTHS DAYS HOURS MIN 8000 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Beth. Ret. & Nursing Ctr.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home		
13a STATE MD			13b COUNTY Mont.		13c CITY OR TOWN Springfield		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 5701 Newington Rd. 20816	
14 FATHER'S NAME FIRST MIDDLE LAST Michael Hurney			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Lane			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b SOCIAL SECURITY NO 125-03-9644			17 INFORMANT ADDRESS MD 20815 Joseph R. Clancy 5454 WI Ave. Chevy Chase							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) atrial fibrillation										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8 PART I OR PART II)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) (the hospital) attended the deceased from 3-7-1986 to 10-10-1987 that (I) (we) lost saw the deceased alive on 8-22-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Russell M. Tilley, Jr. M.D.						DEGREE M.D.		22c DATE SIGNED 10-10-87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, Jr. M.D.						22e ADDRESS 4701 MA Ave. NW Wash., DC 20016				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/14/87		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Wash., DC			
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 3130 WI Ave. NW Wash., DC 20016						25a DATE REC'D. BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial request permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1-44-CHINESE

White 79 X

DO 11.11

Richards Beth. Nat. & Nursing Ctr. Home

MD Home Springfield X 7200 Newington Rd. 27-18

Michael Runway Catherine Lane
155-0-8844 Joseph H. Clancy 5454 MI Ave. Chevy Chase
NO 20013

Manuel N. Willey, Jr. N.D. 4703 MI Ave. NW Wash., DC 20016

Manuel 10/15/61 Mt. Olivet Cem. Wash., DC

10/15/61 Joseph Willey's Son, Thos. 5110 MI Ave. NW Wash., DC 20016
OCT 16 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

FOR
1- STATE
REGISTRAR
NOV-287

1- STATE REGISTRAR NOV-287			2a DATE OF DEATH MONTH DAY YEAR October 28, 1987			2b HOUR 8:00 AM		
3 SEX Male			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR April 17, 1913		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Clarksburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12825 Piedmont Rd.			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b KIND OF BUSINESS OR INDUSTRY Refrigeration					
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Clarksburg		
14 FATHER'S NAME FIRST MIDDLE LAST Urner S. Purdum			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olea Burdette			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-03-0474			17 INFORMANT ADDRESS Clarksburg, Md. 20871			18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinomatous - Co of Bladder</u>		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			19c AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21c LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>8/13/82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.			22b SIGNATURE <u>Stephen N. Jones</u>			22c DATE SIGNED 10/28/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones, M.D.			22e ADDRESS 809 Viers Mill Rd., Rockville, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 30, 1987			23c NAME OF CEMETERY OR CREMATORY Clarksburg Meth.		
23d LOCATION CITY OR TOWN COUNTY STATE Clarksburg, Montgomery, Md.			24 FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.			25a DATE REC'D BY REGISTRAR OCT 30 1987		
25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								

0710318-101-251

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Bureau" and "Department" are faintly visible.]

068552 OCT 14 87

Item #1, G-632, 10/20/87, by F.H., / Gbl. STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) THOMAS F. Quinn MD		2a DATE OF DEATH MONTH DAY YEAR 10-12-87		2b HOUR 1:10	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 12 24 13	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b USUAL BUSINESS OR INDUSTRY Self Employed		13a STREET ADDRESS / ZIP CODE 11706 New Hamp Ave, 20904	
13b STATE Maryland		13c CITY OR TOWN Montgomery Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Quinn		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Coyle		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A (IF YES, GIVE WAR OR DATES)	
16b SOCIAL SECURITY NO. 578 22 1486		17 INFORMANT ADDRESS Billie Quinn (Wife) Same as 13E			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Ventricular Fibrillation/tachycardia DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (this hospital) attended the deceased from October 3, 1987 to October 12, 1987 , that (I/we) last saw the deceased above , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.					
22b SIGNATURE William W. Fullner MD		DEGREE M.D.		22c DATE SIGNED 10/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) William W. Fullner M.D. FACC		22e ADDRESS 11251 Lockwood Drive, Silver Spring, Md 20901			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/15/87		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.		24 FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp.S.S.Md.			
25a DATE REC'D. BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE Julia Anderson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward certificate papers, Pages 1 and 2, should be filed with a 22 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as a cause.

BP

088225 OCT 14 83

100% Cotton 100% Polyester
100% Cotton 100% Polyester
100% Cotton 100% Polyester
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Colorfast
Washable

100% Cotton 100% Polyester
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

2 DECEASED NAME (PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
Lois W. RAY					October 22, 1987	6:00P _M
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	7b HOUR	
Female	White	May 23, 1911		76		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	American			Montgomery County MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Damascus	25156 Tralee Court		Homemaker			
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	
Maryland		Montg.	Damascus		25156 Tralee Court 20872	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Clarence Davis		Sadie Layton				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS		
No		214-36-3271		Parker Watkins 26606 High Street Damascus, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>H.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Seconds</u> <u>Years</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE		
22 I certify that (1) (this hospital) attended the deceased from 19 <u>59</u> to <u>Oct. 22</u> 19 <u>87</u> that (1) (the) lost saw the deceased alive on <u>Oct. 22</u> 19 <u>87</u> and that in my (my) own opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death						
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED
<u>Jack Schumacher M.D.</u>						Oct. 23, 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				
Jack Schumacher, M.D.		105 Russell Avenue, Gaithersburg, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial	10/25/87	Bethesda Cemetery		Browningsville, Md.		
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE		
Olin L. Molesworth, P.A., Damascus, Md.				Oct 26 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified in writing.

0 6 2 5 2 0 2 1 5 1

071224 NOV 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate should be retained by the funeral director for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 99999
 DMMH 10-200M 7/84
 (VRA 15, 4)

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD EVAN REDMON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 31 1987		2b. HOUR P M 6:20 P		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 21 1918		6. AGE (IN YEARS LAST BIRTHDAY) YRS 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE VIRGINIA		13b. COUNTY ALEXANDRIA		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL REDMON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA BENNETT		13e. STREET ADDRESS / ZIP CODE 400 MADISON STREET #602 22314			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1944-1971		17. INFORMANT ADDRESS DOROTHY M. REDMON, 400 MADISON STREET, #602, ALEXANDRIA, VA 22314			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC RECTAL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 26 19 87 to OCTOBER 31 19 87 that (I) (we) last saw the deceased alive on OCTOBER 31 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J. A. Swenson</i> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 02 Nov 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. A. SWENSON, LT, MC, USN				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-4-87		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Everly-Wheatley Funeral Home 1500 W. Braddock Rd. Alexandria, Va.				25a. DATE REC'D. BY REGISTRAR NOV 05 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Sanders-Randall</i>	

MEDICAL CERTIFICATION

151551 101-0 51

069059 OCT 26 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30092

1 DECEASED NAME (TYPE OR PRINT) FIRST <u>JOSEPH</u> MIDDLE <u>S.</u> LAST <u>REICH</u> <i>Joseph S. Reich</i>		2a. DATE KNOWN OF DEATH ESTIMATED DATE MONTH <u>10</u> DAY <u>15</u> YEAR <u>1987</u>	
3 SEX <u>MALE</u>	4 RACE <u>WHITE</u>	5 DATE OF BIRTH MONTH <u>02</u> DAY <u>28</u> YEAR <u>1925</u>	6 AGE (IN YEARS) (LAST BIRTHDAY) <u>62</u> YRS. IF UNDER 1 YR. MONTHS <u>00</u> DAYS <u>00</u> HOURS <u>00</u> MIN <u>00</u> IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u>		7b CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD	
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>St. Cross Hosp</u>	
12a USUAL OCCUPATION (TYPE OF WORK) <u>PATENT EXAMINER</u>		12b KIND OF BUSINESS OR INDUSTRY <u>20910</u>	
13a MARYLAND <u>MONTGOMERY</u>		13b INSIDE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c STREET ADDRESS <u>5503 Sundale Dr</u>		14 FATHER'S NAME FIRST <u>SIMON</u> MIDDLE <u>REICH</u> LAST <u>MAY</u>	
15. MOTHER'S MAIDEN NAME FIRST <u>KALISH</u> MIDDLE <u>COLBY</u> LAST <u>COLBY</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>	
16b SOCIAL SECURITY NO. <u>171-12-0710</u>		17 INFORMANT <u>LEONARD S. REICH, WATERVILLE, MAINE</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>			
19a DATE OF OPERATION <u>None</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. <u>1299</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>DR. JOHN S. ROGERS, M. D.</u>		ADDRESS <u>1919 SEMINARY ROAD SILVER SPRING, MARYLAND</u>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b DATE <u>10/18/1987</u>	
23c NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		23d LOCATION CITY OR TOWN <u>FALLS CHURCH, VIRGINIA</u> COUNTY <u>FAIRFAX</u> STATE <u>VA</u>	
24 DONALDSON STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a DATE REC'D. BY REGISTRAR <u>OCT 21 1987</u>	
25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodwell</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL, ITEM 18, WITHIN 72 HOURS AFTER DEATH. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (1))

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069727 OCT 26 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JEFFERY AUSTIN RICHARDS			2a DATE OF DEATH MONTH DAY YEAR 10 / 20 / 87		2b HOUR 3:15 P.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1961		6 AGE (IN YEARS LAST BIRTHDAY) 26	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) Wash. D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Parts Driver	12b PUBLIC INDUSTRY Chevy Chase Chevrolet	
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Richards			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Odum		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-80-0715	17 INFORMANT ADDRESS Barbara Richards 201 E. Argyle Rockville, Md. 20850 (sister-in-law)			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) chronic renal failure, sepsis					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD	
22a I certify that (1) this hospital attended the deceased from January 1987 to Oct 20 1987 that (2) we last saw the deceased alive on Oct 20 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death.					
22b SIGNATURE Mark Rosen MD		DEGREE		22c DATE SIGNED 10/21/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen		22e ADDRESS Silver Spring MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/22/87	23c NAME OF CEMETERY OR CREMATORY St. Mary's Catholic Church Cemetery Rockville, Md.		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a DATE REC'D. BY REGISTRAR OCT 23 1987			
		25b REGISTRAR'S SIGNATURE Julia Dwyer-Rudolph			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (1) or (2), the medical examiner must be notified at once.

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069060 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. These permits remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then an autopsy, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH 16 60M 7:84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30094

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH G. Ridgley			2a. DATE OF DEATH MONTH DAY YEAR 10-14-87		2b. HOUR 2:53 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 1, 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS, LAST BIRTHDAY) 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST FRED - PRIDE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH - (UNKNOWN)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-22-2261		17. INFORMANT ROBERT E. RIDGLEY (SON)		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Cirrhosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hepatic encephalopathy Pneumonia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 85 14 Oct 87		
22a. I certify that (1) (this hospital) attended the deceased from above, (2) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE Merton L. White MD		DEGREE		22c. DATE SIGNED 14 Oct 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Merton L. WHITE, M.D.		22e. ADDRESS 9911 Georgia Ave 55, MD 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT/16/87		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING, MONT CO, MARYLAND		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 19 1987 Julia Harrison-Pedersen				
24. FUNERAL DIRECTOR NAME ADDRESS CHARLERS FUNERAL HOME SILVER SPRING, MARYLAND						

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520 JOURNAL OF POST KEYNESIAN ECONOMICS

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MARIETTA ELENA RILEY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 5 1987		2b HOUR P M 8:59 P	
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 14 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN		12b KIND OF BUSINESS OR INDUSTRY Beauty Shop	
13a STATE MARYLAND	13b COUNTY Prince George's	13c CITY OR TOWN HYATTSVILLE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 6721 CALVERTON DRIVE 20782		

14 FATHER'S NAME FIRST MIDDLE LAST MICHAEL RONCA		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA NICOLA RUSSO	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 181-07-4034	17 INFORMANT ADDRESS MAMIE HANNA, 6721 CALVERTON DRIVE, HYATTSVILLE, MD 20782	

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NON-SMALL CELL LUNG CARCINOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF		
(c) _____		

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from **OCTOBER 5, 1987** to **OCTOBER 5, 1987** that (I) (we) last saw the deceased alive on **OCTOBER 5, 1987** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <i>Westby G. Fisher</i>	DEGREE MD	22c DATE SIGNED 6 OCT 5 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) WESTBY G. FISHER, LT, MC, USN		22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 10-7-87	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d LOCATION (CITY OR TOWN COUNTY STATE) Alexandria, Virginia
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc.		25a DATE REC'D. BY REGISTRAR OCT 8 1987	25b REGISTRAR'S SIGNATURE <i>Julia Anderson</i>
P. O. Box 43352, Washington, DC 20010			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once. **Cleared by Medical Examiner 10/28/87**

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR
Dexter V. Rivenburgh						10			28	87		9:11 P.M.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 12 HRS	
MALE	WHITE		MONTH DAY YEAR 02 10 -98			89 YRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD			
New York	USA					Montgomery						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Olney	Montgomery General Hospital			Retired			Dept. of Agriculture					
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			
Maryland			Montgomery			Derwood			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET ADDRESS / ZIP CODE						
William F. Rivenburgh			Inez Vosburgh			17720 Caddy Drive 20855						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			
Yes			WW I			215-44-8623			Barbara A. Hall (daughter) sameas 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOVOLEMIC SHOCK</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ATHEROSCLEROSIS OF AORTA</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>HYPERTENSION</u>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
10/28/87			RUPTURED ANEURYSM			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 (a) OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>10/28</u> 19 <u>87</u> to <u>10/28</u> 19 <u>87</u> , that if (we) last saw the deceased alive on <u>10/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
<u>Garry Ruben</u>			MD						10/28/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS									
Dr Garry Ruben			11120 New Hampshire Ave. #307 Silver Spring, Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION			
Burial			11/2/87			Cedar Hill Cemetery			Suitland, Maryland			
24 FUNERAL DIRECTOR			25a DATE RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852			NOV 02 1987			<u>Garry Ruben</u>						

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ROBERTS

CHIEF OF POLICE

STATION OF INVESTIGATION

OCT 27 1971

070354 OCT 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES E. ROCHFORD			2a DATE OF DEATH MONTH DAY YEAR 10 23 87			2b HOUR 12 40 PM	
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 8 07 97		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY, USA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gardener		12b KIND OF BUSINESS OR INDUSTRY High School	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas E. Rochford		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane O'Neil		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 436-03-6529	
17 INFORMANT Edna W. Rochford		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Uremia							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/22 87 to 10/23 87 , that (I/we) lost saw the deceased alive on 10/23 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b SIGNATURE Myron L. Lenkin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 26, 1987		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a DATE REC'D BY REGISTRAR OCT 29 1987		25b REGISTRAR'S SIGNATURE [Signature]			
500 University Blvd., W. Silver Spring, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070353 OCT 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 1, 2, and 3. Page 1 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A LAST ROGERS					2a DATE OF DEATH MONTH DAY YEAR 10 19 87			2b HOUR 2:03 P.M.	
3 SEX FEMALE		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 1 25 03		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7 IF UNDER 1 YEAR MONTHS DAY HOUR MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDITOR		12b KIND OF BUSINESS OR INDUSTRY CHURCH	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12007 BROOKHAVEN DRIVE 20902	
14 FATHER'S NAME FIRST MIDDLE LAST FRED HENDRICKSON					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TRESSIE MCGUIRE				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 220-34-9033		17 INFORMANT DAUGHTER BETTY MCCONKEY		ADDRESS 170 PLANK ROAD GETTYSBURG, PA 17325			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) <u>the hospital</u> attended the deceased from <u>19 OCT 19 87</u> to <u>19 OCT 19 87</u> that (I) <u>last</u> saw the deceased alive on <u>19 OCT 19 87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.									
22b SIGNATURE <u>Walter E. Goetz</u> MD					22c DATE SIGNED 19 OCT 87			22d PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD	
22e ADDRESS 2709 SHOREFIELD RD WHEATON MD					22f ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT21,1987		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					25a DATE REC'D. BY REGISTRAR OCT 29 1987		25b REGISTRAR'S SIGNATURE <u>John D. ...</u>		

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved.

2. The second part of the report is a detailed description of the methodology used in the study. It includes a description of the data collection methods and the statistical analysis techniques used.

3. The third part of the report is a discussion of the results of the study. It includes a description of the findings and a comparison of the results with the objectives of the project.

4. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides recommendations for future research. The references list the sources of information used in the study.

5. The fifth part of the report is an appendix containing supplementary information. This includes a list of abbreviations and a glossary of terms used in the report.

6. The sixth part of the report is a bibliography. This lists the sources of information used in the study, including books, articles, and other documents.

069474 OCT 23 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) ROBERT ROSENBAUM			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 19, 1987		2b HOUR 4:25 AM
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JAN 22 1912		6 AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR WEEKS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1121 UNIVERSITY BLVD WEST #1116		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AREO ENGINEER	12b KIND OF BUSINESS OR INDUSTRY FED AVIATION ADMINISTRATION	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Florida	13b COUNTY Sarasota	13c CITY OR TOWN Sarasota	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2521 Riverbluff Pkwy 34231	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB ROSENBAUM		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEAH LEVINE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO. 118-18-0935	17 INFORMANT ADDRESS ADELE ROSENBAUM/WIFE/SAME AS 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Melanoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from July , 19 87 , to Oct , 19 87 that (I) (we) last saw the deceased alive on Oct 19 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE FPSmith		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-19-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. FRED SMITH		22e ADDRESS 5401 WESTERN AVENUE, NW WASHINGTON, DC			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b DATE OCT 19, 1987	23c NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE Lelia Davidson-Hordell	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MOBILE COUNTY

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MORRIS MIDDLE H. LAST ROSENBERG			2a DATE OF DEATH MONTH DAY YEAR Oct. 2, 1987		2b HOUR 8:20p M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH March 19, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 70 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 20 Farmington Ct.		12a USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) Physician		12b KIND OF BUSINESS OR INDUSTRY Health Care
13a STATE Florida		13b COUNTY Palm Beach		13c CITY OR TOWN Singer Island		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST Jacob MIDDLE ROSENBERG LAST		15. MOTHER'S MAIDEN NAME FIRST Pauline MIDDLE HIRSH LAST		13e STREET ADDRESS / ZIP CODE 5380 No. Ocean Dr., Apt. 22-H 99009		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII 579 18 0428		17 INFORMANT Steven Rosenberg 8621 Coral Gables Lane Vienna, Va. 22180		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Three years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (the hospital) attended the deceased from Aug. 21 19 84 to Oct. 10 19 87 that (I) (X) last saw the deceased alive on Oct. 10 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.						
22b SIGNATURE Harold S. Mirsky				DEGREE M.D.		22c DATE SIGNED Oct. 2, 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) Harold S. Mirsky, M.D.				22e ADDRESS Washington, D.C.		
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE Oct. 5, 1987		23c NAME OF CEMETERY OR CREMATORY King David Memorial Gardens		23d LOCATION Falls Church, Fairfax Co., Virginia
24 FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Virginia 22046				25a DATE REC'D. BY REGISTRAR OCT 07 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

069580 OCT 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Etta		Rubin		10-17-87		8		56A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR 02 2 08		79 YRS		MONTH DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
BROOKLYN, N.Y.	U.S.A.			Montgomery County MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda, MD	Suburban Hospital			CLERK		GOODWILL			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6121 MONTROSE RD. (20852)	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
DAVID RUBIN		ESTHER SILVERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT					
NO		213-40-7546		NIECE SILVER SPRING, MD DEVOIRA SHERMAN: 713 HERMLEIGH RD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Probably Myocardial Infarction</u>								1 day.	
(c) <u>Coronary Artery Disease</u>								years.	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>10-17-87</u> to <u>10-17-87</u> that (1) we last saw the deceased alive on <u>10-17-87</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we did not view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>Loreto S. Albiol MD</u>		MD		10-17-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Loreto S. ALBIOL, MD		6121 MONTROSE RD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		10/19/87		OHEV SHOLOM CONG. CEM.		S.E. WASHINGTON, D.C.			
24. FUNERAL DIRECTOR NAME		25. DATE RECEIVED BY REGISTRAR		26. REGISTRAR'S SIGNATURE					
DANZANSKY-GOLDBERG MEMORIAL CHAPEL		OCT 22 1987							
1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Virginia M. RUBY			2a. DATE OF DEATH MONTH DAY YEAR October 28, 1987		2b. HOUR 1:02 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	7. UNDER 1 YEAR 8. 1 YEAR OR MORE
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10901 Watkins Road 20874	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Germantown			
14. FATHER'S NAME FIRST MIDDLE LAST Harry R. Savage		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Osie Poole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO 216-38-6265	17 INFORMANT ADDRESS Eleanor Ramseur, Item 13		

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic Heart Disease		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

Congenitive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1b OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **10/27** 19 **87** to **present** 19 **87** that (I) (we) (all) saw the deceased alive on **10/27/87** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Richard N. Katon MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Oct. 28, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard N. Katon, M.D.		22e. ADDRESS 20528 Germantown Rd., Germantown, Md. 20874	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 30, 1987	23c. NAME OF CEMETERY OR CREMATORY Monocacy	23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Montgomery, Md.
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24 FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.	DATE RECD. BY REGISTRAR NOV 03 1987	REGISTRAR'S SIGNATURE John Richard Landash
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place relative carbon papers. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of case.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) IRWIN SANDERS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 06, 1987		2b HOUR 11 ¹⁵ P.M.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 9 10 00	6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7b HOUR 11 ¹⁵ P.M.
7a BIRTHPLACE RUSSIA	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD		
10 CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME, GIVE RESIDENCE BEFORE ADMISSION) HEBREW HOME OF GREATER WASHINGTON		12a USUAL OCCUPATION (TYPE OF WORK OR BUSINESS) (LIFE) PUBLIC ACCOUNTANT		12b KIND OF BUSINESS OR INDUSTRY BOOKKEEPING
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MARYLAND	13c COUNTY MONTGOMERY	13d CITY OR TOWN ROCKVILLE	13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f STREET ADDRESS / ZIP CODE 263 CONGRESSIONAL LANE 20852 #120	
14 FATHER'S NAME FIRST MIDDLE LAST JACOB SANDERS	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VETTA SEIDMAN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (ES: NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b SOCIAL SECURITY NO 057-03-0414	17 INFORMANT ADDRESS MILDRED SANDERS, 263 CONGRESSIONAL LANE, ROCKVILLE, MARYLAND			
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause or stating the underlying cause lost b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF c) METASTATIC CA OF COLON					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DEMENTIA; DEPRESSION					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM OR PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 10/1 1987 to 10/6 1987 that I (we) last saw the deceased alive on 10/6 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE S. SUDHAKAR		DEGREE		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. SUDHAKAR		22e ADDRESS HEBREW HOME			
23a BURIAL, CREMATION, REMOVAL BURIAL	23b DATE 10/9/1987	23c NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d LOCATION FALLS CHURCH, VIRGINIA	
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N., WASHINGTON, D. C.		25 DATE REC'D BY REGISTRAR OCT 13 1987		25 REGISTRAR'S SIGNATURE Julia Davidson-Randall	

17 05 730 003 06

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JOSEPH J. SANDERS, JR.			OCTOBER 12, 1987			7:20A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
MALE	CAUCASIAN	MAY 16 1914	73 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
CONNECTICUT	USA				MONTGOMERY MD			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING	HOLY CROSS HOSPITAL			DEPT OF AGRICULTURE MOTION				
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE				
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input type="checkbox"/> NO <input type="checkbox"/>	10318 INSLEY STREET 20902				
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
JOSEPH J. SANDERS, SR.			MARGARET YOST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
YES		1942-1946		200-10-0281 BLANCHE K. SANDERS/WIFE/SAME AS 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Ischemia</u> (c) <u>72 hrs</u>								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral Ischemia</u>								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF YES, RECORD MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)				
22a INJURY OCCURRED WHILE AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT HOME <input type="checkbox"/> AT HOME <input type="checkbox"/>		22b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c LOCATION CITY OR TOWN COUNTY STATE				
23a I certify that (1) this hospital attended the deceased from 84/15 to 10/12/87 that (2) we last saw the deceased alive on 10/11/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated								
23b SIGNATURE		23c ADDRESS		23d DATE SIGNED				
DR. ALAN KERMAIER		10313 GEORGIA AVE SILVER SPRING, MD		10/13/87				
23e PHYSICIAN'S NAME (TYPE OR PRINT)		23f ADDRESS		23g DATE SIGNED		23h REGISTRAR'S SIGNATURE		
						Denson-Randall		
23a BURIAL CREMATION, REMOVAL (CHECK ONE)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		OCT15,1987		CEDAR HILL CEMETERY		SUITLAND PRINCE GEORGES MD		
24 FUNERAL DIRECTOR (NAME)				25 DATE OF REGISTRATION				
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				OCT 19 1987				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the local burial permit. For please remove station papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene and the local health officer.

IMPORTANT: If item 21 (a) marked or item 21 (b) shows any injury or other traumatic event, the medical examiner must be notified once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE G. SANDSTROM			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1987		2b HOUR 11:30A M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JULY 22, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTH DAY MIN. IF UNDER 14 YRS MONTH DAY MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1107 OAKVIEW DRIVE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND		13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING		
14 FATHER'S NAME FIRST MIDDLE LAST BIRGER GREVE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GUDRUN MONSEN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO. 096-18-6113		17 INFORMANT ADDRESS ROBERT SANDSTROM/HUSBAND/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulm arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>mdly brain tumor (glioblastoma)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION July '86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) IF WORK <input type="checkbox"/> NON-WORK <input checked="" type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED AT HOME <input checked="" type="checkbox"/> NON-WORK <input type="checkbox"/> WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) this hospital attended the deceased from 8-7 19 63 to 10-29 19 87 that (I) (we) last saw the deceased on 9-30 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE DR. ROY SANDSTROM				22c DATE SIGNED 10-29-87	
22e ADDRESS 7701 CARROLL AVENUE TAKOMA PARK, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 31, 1987		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING MONTGOMERY MD	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Francis J. Collins	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (a), (b), or (c), item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

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068589 OCT 4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30107

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSEMARY G. SANGELEER			2a. DATE OF DEATH MONTH DAY YEAR 10 1 87			2b. HOUR 8:15 PM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 1 27 28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH SILVER SPRING MONTGOMERY MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2401 EVANS DRIVE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPR.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNK.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 498-30-5449		17. INFORMANT ADDRESS RUTH COWAN - sister - s/a			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Carcinoma of the Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Non Hodgkins Lymphoma, Dwarfism</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>February 19 69</u> to <u>Oct 1987</u> that (I) (we) last saw the deceased alive on <u>September 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Israel Spector MD</u>				DEGREE		22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Israel Spector MD				22e. ADDRESS 12001 Ferrara Ave Wheaton Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-2-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR (NAME) State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 09 1987	
				25b. REGISTRAR'S SIGNATURE <u>Freda Davidson-Randall</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place, with the death certificate, in the container for the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Clementine S. Savage			2a DATE OF DEATH MONTH DAY YEAR 10-11-87 →			2b HOUR 11:15 AM				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7 IF DECEASED 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b KIND OF BUSINESS OR INDUSTRY own home		
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS, / ZIP CODE 429 Christopher Ave., 20879	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Sloman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Wertz							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no			16b SOCIAL SECURITY NO 141 18 1030			17 INFORMANT ADDRESS John Snyder, son, see #13				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e.g.) esophageal Cancer										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c, PART FOUR, PAGE 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 4/23 19 86 to 10/1 19 87 that (I) (we) last saw the deceased alive on 10/1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Melinda Wolf					DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Melinda Wolf					22e ADDRESS 20528 Germantown Rd, Germantown, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 1987 Oct. 15		23c NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d LOCATION (CITY OR TOWN) COUNTY STATE Trenton, New Jersey			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey					24a DATE REC'D BY REGISTRAR OCT 14 1987		24b REGISTRAR'S SIGNATURE J. L. Davidson			
FIRM Rockville, Inc. 300 W. Montgomery Av., Rockville, Md.										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be furnished for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

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069937 OCT 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove confidential pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR STATE REGISTRAR		AKA Mae		Scatterday		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
MARY Virginia Scatterday						Oct. 13 87		10 50 a	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR	
Female		White		Sept. 8, 1908		79		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
DC		U.S.A.				Montgomery		MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Housewife		Own Home	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
MD		Mont.		Beth.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5911 Osceola Rd. 20816	
14 FATHER'S NAME (FIRST MIDDLE LAST)		15 MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
Ernest J. Scatterday		Nellie Toomey							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No		214-46-7140		George H. Scatterday		Same as item # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		b. DUE TO, OR AS A CONSEQUENCE OF		c. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
cardiac arrest		atherosclerotic Heart Disease				1 hr			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
multiple cerebral infarcts									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death		19 87		19 87		19 87			
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
MERTON L. WHITE, M.D.		M.D.				13 Oct 87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
MERTON L. WHITE, M.D.		9911 Georgia Ave Silver Spring, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial		10/16/87		Gate of Heaven Cem.		Silver Spring, MD			
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, Inc.		OCT 26 1987		Julia Parker-Rudner					
5130 WI Ave. NW Wash., DC 20016									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 30110

069985 OCT 28 1987

1- FOR STATE REGISTRAR		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
3 SEX		4 RACE	5 DATE OF BIRTH	MONTH	DAY	YEAR	
7a BIRTHPLACE		7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE		13b COUNTY	13c CITY OR TOWN	13d STREET ADDRESS / ZIP CODE			
14a FATHER'S NAME		14b MOTHER'S MAIDEN NAME					
15a WAS DECEASED EVER IN U.S. ARMED FORCES?		15b SOCIAL SECURITY NO.		15c ADDRESS			
16a CAUSE OF DEATH		16b PART I DEATH WAS CAUSED BY		16c IMMEDIATE CAUSE (a)			
16d DUE TO, OR AS A CONSEQUENCE OF		16e CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE		16f DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED			
21d INJURY OCCURRED		21e PLACE OF INJURY		21f LOCATION			
22a I certify that (1) this hospital attended the deceased from May 19 1987 to Oct 15 1987 that (2) I saw the deceased alive on Oct 9 1987 and that in my opinion death occurred on the date and hour and from the causes stated above, (3) I viewed the body after death.							
22b SIGNATURE		22c PHYSICIAN'S NAME		22d ADDRESS		22e DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			

060982 OCT 30 21



069984 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR1- DECEASED NAME
(TYPE OR PRINT)

JESSIE

FIRST

MIDDLE

LAST

M.

Schauermann

2a DATE OF DEATH MONTH DAY YEAR
10-15-872b HOUR
2:25A M

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

OCT. 13, 1905

6 AGE (IN YEARS LAST BIRTHDAY)

82

7a UNDER 1 YEAR

7b 1 YEAR TO 5 YEARS

7c 5 YEARS TO 10 YEARS

7d 10 YEARS TO 15 YEARS

7e 15 YEARS TO 20 YEARS

7f 20 YEARS TO 25 YEARS

7g 25 YEARS TO 30 YEARS

7h 30 YEARS TO 35 YEARS

7i 35 YEARS TO 40 YEARS

7j 40 YEARS TO 45 YEARS

7k 45 YEARS TO 50 YEARS

7l 50 YEARS TO 55 YEARS

7m 55 YEARS TO 60 YEARS

7n 60 YEARS TO 65 YEARS

7o 65 YEARS TO 70 YEARS

7p 70 YEARS TO 75 YEARS

7q 75 YEARS TO 80 YEARS

7r 80 YEARS TO 85 YEARS

7s 85 YEARS TO 90 YEARS

7t 90 YEARS TO 95 YEARS

7u 95 YEARS TO 100 YEARS

7v 100 YEARS AND OVER

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery Co.

MD

10 CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

National Lutheran Home

12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)

Homemaker

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Prince Geo.-Mt. Rainier

13c CITY OR TOWN

S. x

13d INSIDE CITY LIMITS?

NO ☐

13e STREET ADDRESS / ZIP CODE

2700-Allison St., 20822

14 FATHER'S NAME

Clifford

15 MOTHER'S MAIDEN NAME

V. Smith

Margaret

16

Howell

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

217-52-9759

17 INFORMANT

ADDRESS

REV. DR. REICHARD- N.L.H.-ROCKVILLE, MD.

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Septicemia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) Herpes Zoster

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

2 weeks

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION (STREET)

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from July 7 19 77 to Oct 15 19 87 that (I) (we) last saw the deceased alive on Oct 14 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10-15-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

HAROLD F. McCANN

22e ADDRESS

4362-26th ST N ARLINGTON, VA 22207

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

OCT. 19, 1987

23c NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY- SUITLAND, MARYLAND

23d LOCATION (CITY OR TOWN)

COUNTY

STATE

24 FUNERAL DIRECTOR

NAME

HYSONG CO., INC.-1300-N ST., NW WASH. DC

ADDRESS

25a DATE REC'D BY REGISTRAR

OCT 27 1987

25b REGISTRAR'S SIGNATURE

Julia F. Funder-Rudner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

130570-402000



69595
069595

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilmer Paul Scheer						2a. DATE OF DEATH MONTH DAY YEAR October 15, 1987			2b. HOUR 5:15 PM		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR January 24, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7 UNDER 1 YEAR 8 UNDER 24 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13413 Glen Mill Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electricial Eng.		12b KIND OF BUSINESS OR Naval Sea Systems Command			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13413 Glen Mill Road 20850			
14 FATHER'S NAME FIRST MIDDLE LAST Reinhold Scheer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Wilke							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 387-10-0537		17 INFORMANT Mildred R. Scheer				ADDRESS same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Astrocytoma Cerebellum DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (the XXXX) attended the deceased from May 16, 1961 to October 15, 1987 that (I) (we) last saw the deceased alive on October 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE Horace W. Bernton, M.D.								DEGREE		22c DATE SIGNED October 16, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton, M.D.								22e ADDRESS 4743 Bradley Blvd. Chevy Chase, Md. 20815			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Oct. 19, 1987		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland				
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, Md.						25a DATE REC'D BY REGISTRAR OCT 22 1987					

LA 57

NO. 100-111-11111

100-111-11111

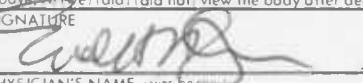
089279 OCT 21 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										30115	
2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA SIFORD SCHMIDTLEIN						2a. DATE OF DEATH MONTH DAY YEAR 10/14/87		2b. HOUR 246 P.M.			
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR 6/21/37		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNITED KINGDOM		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) APPRAISER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE					
13a. STATE MARYLAND				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severna Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick George Siford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Dorothy Landell		16. STREET ADDRESS / ZIP CODE 164 Perrywood Drive / 21146					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-58-4187		17. INFORMANT ADDRESS Frank A. Schmidtlein (Same as #13)							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>METASTATIC BREAST CANCER TO LUNGS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFLAMMATORY BREAST CANCER</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs 4 MTS 16 MTS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2]					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (this hospital) attended the deceased from April 10 1986 to October 14 1987 that (I) (we) lost saw the deceased alive on October 14 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.											
22b. SIGNATURE  M.D.						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVERARD H. HUGHES						22e. ADDRESS 5300 CORPORATE DRIVE LANDOVER MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10-15-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION (CITY OR TOWN COUNTY STATE) Westview BALTIMORE MD				
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO						25a. DATE REC'D. BY REGISTRAR OCT 20 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
ADDRESS SEVERNA PARK, MD. 21146											

MEDICAL CERTIFICATION

068700 OCT 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30114

1- FOR STATE REGISTRAR		2- REG NO	
1 DECEASED NAME (TYPE OR PRINT) Gladys Ruth Schruben		2a DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 10-9 1987 2b HOUR 1852	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH 4 DAY 7 YEAR 10	6 AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b CITIZEN OF WHAT COUNTRY? United States	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hosp.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE MD		13b COUNTY Montgomery	13c CITY OR TOWN Rockville
14 FATHER'S NAME FIRST Garrett MIDDLE Buikstra LAST Lydia		15 MOTHER'S MAIDEN NAME FIRST Lydia MIDDLE Poppen LAST Poppen	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b SOCIAL SECURITY NO. 216-46-2783	
17 INFORMANT Luke Schruben, same as #13		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Chronic obstructive pulmonary disease. DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE John Tauber		TITLE (SPECIFY) Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		DATE SIGNED 10-10-87 Pat Hede	
ADDRESS 8218 Wisconsin Ave			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 14, 1987	
23c NAME OF CEMETERY OR CREMATORY Sunset Cemetery		23d LOCATION CITY OR TOWN Manhattan, Kansas COUNTY STATE	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a DATE REC'D BY REGISTRAR OCT 14 1987	
Rockville, Inc. 300 West Montgomery Ave. Rockville, MD		25b REGISTRAR'S SIGNATURE John Tauber	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FIVE PAGES 1, 2, AND 3. PAGE 5 IS FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

066100 OCT 1967

SEP-44-3042



066100 OCT 1967

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME

FIRST

MIDDLE

LAST

ANNE WEINREB SCHWARTZ

2a. DATE OF DEATH

MONTH

DAY

YEAR

OCTOBER 24, 1987

2b. HOUR

2:20 PM

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH

DAY

YEAR

SEPT 28 1901

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

N.Y.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6205 STARDUST LN. BETH MD.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER

12b. KIND OF BUSINESS OR INDUSTRY

HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

MONTG.

13c. CITY OR TOWN

ROCKVILLE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE (20852)

10500 ROCKVILLE PK., #208

14. FATHER'S NAME

SAMUEL

MIDDLE

WEINREB

LAST

15. MOTHER'S MAIDEN NAME

TILLIE

MIDDLE

GREENBERG

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

N/A

17. INFORMATION

6205 STARDUST LA. BETHESDA, MD.

ADDRESS

MRS. BARBARA MENDEL (daughter)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) urosepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Severe degenerative arthritis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

advanced age

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (a) (this hospital) attended the deceased from 19 83 to October 19 87 that (b) (we) last

saw the deceased alive on Oct 20 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated

above (b) (we) (did) (did not) view the body after death

22b. SIGNATURE

Barbara Blaylock

DEGREE

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☒DIRECTOR ☐PHYSICIAN ☐

22c. DATE SIGNED

10/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Barbara Blaylock, M.D.

22e. ADDRESS

6111 Executive Blvd., Rockville, Md. 20852

23a. BURIAL, CREMATION, REMOVAL

(SPEC.)

CREMATION

23b. DATE

OCT 25 1987

23c. NAME OF CEMETERY OR CREMATORY

LEE CREMATORY

23d. LOCATION

CITY OR TOWN

WASHINGTON, D.C.

COUNTY

STATE

24. FUNERAL HOME

DANZANSKY-GOLDBERG MEMORIAL CHAPEL

25a. DATE REC'D. BY REGISTRAR

OCT 28 1987

25b. REGISTRAR'S SIGNATURE

John P. ...

1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

50 25 130 25 10 50

068892 OCT 19 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

30116

REG NO

1. DECEASED NAME (TYPE OR PRINT) HERMAN SCHWARTZ			2a. DATE OF DEATH MONTH DAY YEAR OCT 14 1987			2b. HOUR 8:50 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1916		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rabbi		12b. KIND OF BUSINESS OR INDUSTRY Clergy	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Schwartz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Goldscheider			13e. STREET ADDRESS / ZIP CODE 2935 Birchtree Lane (20906)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-54-9674		17. INFORMANT ADDRESS Freyda Schwartz; Wife; 2935 Birchtree Lane;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4 DAYS YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a RENAL FAILURE, DIABETES, SEPSIS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from MAY 19 1982 to OCT 14 19 87 that (1) (two) last saw the deceased alive on OCT 14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Martin C. Shargel			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL			22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON MD - 20895						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY B'Nai Israel Cong. Cemetery, Oxon Hill, P.G. Adams		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (FIRST, MIDDLE, LAST) SONYA M. SCHWEITZER			2a. DATE OF DEATH MONTH DAY YEAR Oct. 30, 1987			2b. HOUR 10 ³⁰ AM				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 11 23 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BAYONNE N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MD.			13b. COUNTY MONTG.		13c. CITY OR TOWN WHEATON MD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3911 MINDEN RD. 20902	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID GOLDSTEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FAY HELFAND							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 3413 GLENN DR. SUITLAND MD. MR. MARC-SCHWEITZER (son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PROBABLE ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (b) END-STAGE METASTATIC BREAST CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/28 19 87 to 10/30 19 87 that (I) (we) last saw the deceased alive on 10/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joel Kalman						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL KALMAN						22e. ADDRESS 6111 EXECUTIVE BLVD, ROCKVILLE MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-1-87		23c. NAME OF CEMETERY OR CREMATORY JUDAN MEM Gdns			23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY MD.		
24. FUNERAL HOME OR ADJUTANT DANZANSKY-GOLDBERG MEM. CHPS INC. 1170 ROCKVILLE PK. ROCKVILLE MD.						25a. DATE REC'D. BY REGISTRAR NOV 04 1987		25b. REGISTRAR'S SIGNATURE Julia Sander-Randall		

050048-205

068348 OCT 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30118

1 DECEASED NAME (TYPE OR PRINT) Elizabeth Mundy Scott			2a DATE OF DEATH MONTH DAY YEAR Oct. 4, 1987		2b HOUR 7:33p M
3 SEX Female	4 RACE caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jan. 07, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Mexico	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Fla.	13b COUNTY Duval	13c CITY OR TOWN Jacksonville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1311 Windsor Place/32205	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Mundy		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Lewis			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 262-50-9567		17 INFORMANT 3002 Albemarle St., NW Elizabeth Adams, Washington, D.C. 20008	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 6yr.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from July 13, 1985 to Oct. 4, 1987 that (I) (we) last saw the deceased alive on Sept. 19, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b SIGNATURE Wesley M. Oler DEGREE				22c DATE SIGNED Oct. 4, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Wesley M. Oler			22e ADDRESS 3301 New Mexico Ave. N.W. Washington D.C. 20016		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit	23b DATE 10/9/87	23c NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Norwalk, Conn.	
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a DATE REC'D BY REGISTRAR OCT 09 1987 25b REGISTRAR'S SIGNATURE Julia Dendron-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 - FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

(TYPE OR PRINT)

Parker

Scripture

10 22 87

10:10 PM

3 SEX

Male

4 RACE

Caucasian

5 DATE OF BIRTH

8 1 11

6 AGE (IN YEARS LAST BIRTHDAY)

76

YRS

MONTHS

DAYS

HOURS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

New York

7b CITIZEN OF WHAT COUNTRY?

USA

MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY COUNTY, MD

10 CITY OR TOWN OF DEATH

SANDY SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

FRIENDS NURSING HOME

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Owner

12b KIND OF BUSINESS OR INDUSTRY

Nursery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE Zip: 20906

3429 S. Leisure World Blvd.

14 FATHER'S NAME

Parker

FIRST

MIDDLE

LAST

Scripture

15 MOTHER'S MAIDEN NAME

Laura

FIRST

MIDDLE

LAST

Wilson

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b SOCIAL SECURITY NO

118-16-1974

17 INFORMANT

ADDRESS

Mrs. Janet Scripture, Wife, same as #13

18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiopulmonary ex pector

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10/22/87

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Pulmonary embolism, 6-bleed, CVA

10/11/87

DUE TO, OR AS A CONSEQUENCE OF

(c) OMI, 1, 1986

1986

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Hyp

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)

21f LOCATION STREET

CITY OR TOWN

COUNTY

STATE

21g WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22a I certify that (I) (this hospital) attended the deceased from 1/22 19 87 to 10/22 19 87 that (I) (we) last saw the deceased alive on 10/22 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death

22b SIGNATURE

Arthur Schwab

DEGREE

MD

22c ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d DATE SIGNED

10/23/87

22e PHYSICIAN'S NAME (TYPE OR PRINT)

Arthur Schwab

22f ADDRESS

1811 Prime Pkwy, Ste 203, Rockville, MD 20852

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

October 26, 1987

23c NAME OF CEMETERY OR CREMATORY

Rome Cemetery

23d LOCATION CITY OR TOWN

Rome

COUNTY

STATE

New York

24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/

Rockville, Inc.

300 W. Montgomery Avenue, Rockville, Maryland

25a DATE REC'D BY REGISTRAR

OCT 27 1987

25b REGISTRAR'S SIGNATURE

John T. R. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, allows any injury, or other traumatic event, the medical examiner must be notified of case.

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REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a DATE OF DEATH MONTH DAY YEAR				7b HOUR	
BENJAMIN NEWTON SEBASTIAN, Jr.						AUGUST 16 1987				12:10 ^a	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTH DAY HOURS	
MALE		WHITE		MARCH 18, 1974			13 YRS				
7a BIRTHPLACE (COUNTRY) STATE OR FOREIGN			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Texas			USA						MONTGOMERY COUNTY MD		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NIH, THE CLINICAL CENTER			Student					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e STREET ADDRESS / ZIP CODE					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT 1, BOX 363		28669	
NORTH CAROLINA		13b COUNTY		ROARING RIVER							
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Benjamin N. Sebastian, Sr.						Jeri Holloway					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)			17 INFORMANT ADDRESS					
no			000-00-0000			WILLIAM J. SEBASTAIN FATHER					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Intracranial involvement by Ewing's sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (b) (this hospital) attended the deceased from <u>MAY 6</u> 19 <u>87</u> to <u>AUGUST 16</u> 19 <u>87</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>AUGUST 16</u> 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.											
22b SIGNATURE						DEGREE			22c DATE SIGNED		
<i>Shizuko Aoki</i>									8/16/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
Shizuko Aoki M.D.						NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE			
Removal			8-18-87		Reins-Sturdivant Funeral Home			No. Wilkes-Barre, NC			
24 FUNERAL DIRECTOR NAME ADDRESS						25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Marshall's Funeral Home 4217 9th St NW: Washington, D.C.						AUG 26 1987			<i>Davidson-Hendall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Linda Carol Selke			2a. DATE OF DEATH MONTH DAY YEAR 10 8 87		2b. HOUR 10 23 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 17 1943		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS, LAST BIRTHDAY) YRS MONTHS DAYS 43		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ARV HOSP		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Harrison Ellison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Marie Campbell		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Bernard Earl Archer (husband) same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pericardial effusion DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Coumadin Therapy to Deep vein Thrombosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from May 8, 1977 to Oct 8, 1987 that (I) (we) last saw the deceased alive on Oct 7, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Charles W. Karesch				22c. DATE SIGNED 10/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARESCH				22e. ADDRESS 12029 Devilwood Dr. Potomac, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md.		25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Kendall		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene in Baltimore, or removal.

IMPORTANT: If item 21 is marked as item 18, there may be injury or other traumatic event; the medical examiner must be notified at once.

BP

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Handwritten text at the bottom of the page, including the date "OCT 12 1961" and other illegible markings.

68338 OCT 13 87

FOR
STATE
REGISTRAR

AKA Margaret

Seren Gulian

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AKA Margaret Serengulian Serengulian Serengulian			2a. DATE OF DEATH MONTH DAY YEAR 10 1 87		2b. HOUR 11:30 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HRS. MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Armenia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Jeweler
13a. STATE MD		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4803 Broadbrook Rd. 20814
14. FATHER'S NAME FIRST MIDDLE LAST Asdig Ougourlian		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zarouhi Narvouzian		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 109-09-6449		17. INFORMANT Arsen Serengulian		ADDRESS 803 Blossom Dr. Rockville MD 20850	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA, Electrolyte IMBALANCE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC CARCINOMA 2 ym DUE TO, OR AS A CONSEQUENCE OF (c) RENAL CELL CARCINOMA 2 1/2 ym					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1985</u> to <u>100</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>100</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eugene P. Libre MD				22c. DATE SIGNED 2 Oct 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE MD				22e. ADDRESS 10400 CONNECTICUT AVE KENTINGTON, MD 20895	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/6/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016			
25a. DATE REC'D. BY REGISTRAR OCT 09 1987				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of one.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers, Page 2 and 3, and file with n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John Kirk Sewall			2a DATE OF DEATH MONTH DAY YEAR 10-27-87		2b HOUR 2:45AM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR JUNE 12, 1907		6 AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREIGN SERVICE OFF. STATE DEP'T.	
13a STATE Md.		13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST SOLOMON SEGALL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NADYA UNKNOWN		12b KIND OF BUSINESS OR INDUSTRY	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 562-10-0280		17 INFORMANT ADDRESS ROY SEWALL 5619 OAK PL., BETHESDA, Md. 20817	
18 CAUSE OF DEATH Enter only one cause per line for each of the three lines. PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Brain Injury 28h Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Ventricular Fibrillation (Sudden Death) 28h					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Renal Failure, CARDIOMYOPATHY, Hypertension					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a ALIOPS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10/25 19 87 to 10/27 19 87 that (I) (we) last saw the deceased alive on 10/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b SIGNATURE John Yelverton		DEGREE MD		22c DATE SIGNED 10/27/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN YELVERTON		22e ADDRESS 10401 OLD GEORGETOWN Rd. BETHESDA, Md. #204			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-28-1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	
23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.		25a DATE REC'D. BY REGISTRAR NOV 2 1987			
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		25b REGISTRAR'S SIGNATURE John Yelverton			

BP

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]

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069121 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) THETIS E. SHAFFER			2a DATE OF DEATH MONTH DAY YEAR 10 9 87			2b HOUR 8:45 A.M.			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR AUGUST 6, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89		7 UNDER 1 YEAR MONTHS DAYS 89	
7a BIRTHPLACE STATE OR FOREIGN ARKANSAS		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3544 FISKE TERRACE				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMIN ASST		12b KIND OF BUSINESS OR INDUSTRY FEDERAL GOV'T	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3544 FISKE TERRACE 20906	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM MARTIN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA PRESCOTT						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-52-7539		17 INFORMANT ADDRESS ROY SHAFFER/HUSBAND/SAME AS 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <u>Chronic Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>10/6/87</u> to <u>10/9/87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.									
22b SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <u>10/9/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Allan B. Cohan				22e ADDRESS 13975 Conn. Ave. Silver Spring, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT 12, 1987		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD			
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This certificate is not valid unless it is signed by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene seal to be used in lieu of a signature.

IMPORTANT: If item 21 is marked or item 18, (a), (b), (c), or (d) is marked, or other trauma or event, the medical examiner must be notified immediately.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer L. SHOEMAKER			2a DATE OF DEATH MONTH DAY YEAR 10 28 87		2b HOUR 12³⁵ PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1931	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10 CITY OR TOWN OF DEATH Germantown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11405 Millport Circle		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	12b KIND OF BUSINESS OR INDUSTRY County Schools	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Germantown			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 11405 Millport Circle 20874	
14 FATHER'S NAME FIRST MIDDLE LAST Owen W. Shoemaker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Violet Kidwell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 214-28-2595	17 INFORMANT ADDRESS 20100 Club Hill Dr. Stewart L. Shoemaker, Germantown, Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years					
MEDICAL CERTIFICATION					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9/19 19 84 to 10/28 19 87 that (1) (we) last saw the deceased alive on 6/29/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) did not view the body after death.					
22b. SIGNATURE Stephen J. Newman		DEGREE MD		22c. DATE SIGNED 10/28/87	
22d. PHYSICIAN'S NAME (TYPE CURRENT)		22e. ADDRESS			
Stephen J. Newman, M.D.		19261 Montgomery Village Ave., Gaithersburg, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 31, 1987	23c NAME OF CEMETERY OR CREMATORY Resthaven		23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR OCT 30 1987		
			25b. REGISTRAR'S SIGNATURE Julia S. [Signature]		

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Richard Douglas Showman			2a DATE OF DEATH MONTH DAY YEAR 10 29 87			2b HOUR 10:37PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 02 01 46		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS		7 UNDER YEAR (IF UNDER 1 YEAR) MONTH DAY HOUR MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? American		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor		12b KIND OF BUSINESS OR INDUSTRY Real Estate	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montg.		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 25131 Chambliss Court 20879	
14 FATHER'S NAME FIRST MIDDLE LAST Jack H. Showman				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Peggy Joyce Troutman					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-46-6756		17 INFORMANT Sandra M. Showman				ADDRESS Item 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we do not sign this body after death)									
22b SIGNATURE <u>Jack Simon MD</u>						DEGREE MD		22c DATE SIGNED 10/29/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jack Simon MD						22e ADDRESS Montgomery Gen Hosp, Olney, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 11/01/87		23c NAME OF CEMETERY OR CREMATORY Wesley Grove		23d LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. Md.		
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a DATE REC'D BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Landell	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

170817 NOV-30

1. The following information was received from the

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16. The following information was received from the

069376 OCT 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1 DECEASED NAME (TYPE OR PRINT) LOUIS Siegel		2a DATE OF DEATH MONTH DAY YEAR 10 17 87		2b HOUR 10:30 PM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 06 14 12	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
10 CITY OR TOWN OF DEATH Olney, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
12a US OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b KIND OF BUSINESS OR INDUSTRY ACCOUNTING			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville	
14 FATHER'S NAME FIRST MIDDLE LAST NATHAN SIEGEL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEAH KAPTIN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF NOT, GIVE VA ID NUMBER) WWII-ARMY 215-03-8132		17 INFORMANT NAME ADDRESS RALPH B. SIEGEL P.O. BOX 95 ST MARY'S CITY, MD 20686	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 22 yr. 22 yr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) pneumonia with Respiratory Failure					
19a DATE OF OPERATION 10-16-87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy for pneumonia		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from 10-12 19 87 to 10-17 19 87 that (I) (we) last saw the deceased alive on 10-17 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Frank J. Mayo, MD				22c DATE SIGNED 10-18-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FRANK J. MAYO, MD				22e ADDRESS 16220 Frederick Rd. #213 Gaithersburg, MD 20877	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT. 20, 1987		23c NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM. PARK	
24 FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215		23d LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD		25a DATE REC'D BY REGISTRAR OCT 21 1987	
				25b REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

000318 OCT 55 81

CONFIDENTIAL

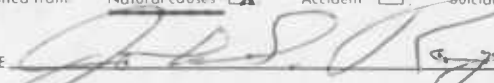
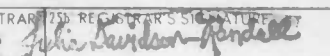
OCT 55 81

69275 OCT 21 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Annie Todd Singleton			7a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10/15 19 87		7b HOUR M 6:50 P.
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1914	6 AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YR. MONTHS DAYS 73	IF UNDER 24 HRS. HOURS MIN 73
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13300 Bea Kay Drive		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring
14 FATHER'S NAME FIRST MIDDLE LAST J.C. Vaughn Todd			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth T. Peters		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown		16b SOCIAL SECURITY NO. 577-60-2349		17 INFORMANT ADDRESS William T. Singleton/ 1330 Bea Kay Drive Silver Spring, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I None					
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH None		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 16, 1987		23c NAME OF CEMETERY OR CREMATORY Lee & Sons	
24 FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc.		ADDRESS 7400 Georgia Avenue, N.W. D.C. 20012		25a DATE REC'D. BY REGISTRAR OCT 20 1987	
25b REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. PAGE 5 SHOULD BE KEPT FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

Stinson

Todd

Amie

Female Black Aug. 10, 1914-25

Montgomery County

Silver Spring 1930 Ben Ray native

Maryland Montgomery Silver Spring 1930 Ben Ray native

Continued on the reverse of page 2.

None

None

None

1914-25

1914-25

Silver Spring, Montgomery County, Md.

John A. Moore, M.D.

70348 OCT 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Don Edward SLEE			2a. DATE OF DEATH MONTH DAY YEAR 10-24-87		2b. HOUR 9:00 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 15 07		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS MONTHS DAYS HOURS MIN		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Marion Care		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13a. STATE New Jersey		13b. COUNTY Morris		13c. CITY OR TOWN Mount Tabor		
14. FATHER'S NAME FIRST MIDDLE LAST Edward M. SLEE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Oliver		12b. USUAL OCCUPATION (INCLUDING IFE) Manager-Group Administration		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 085-09-0202		17. INFORMANT Don J. SLEE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Simpson Avenue 07878		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
21g. I certify that (1) (this hospital) attended the deceased from 6/30 19 81 to 10/25 19 87 that (we) last saw the deceased alive on 9/24 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 10/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. ELG, M.D.		22e. ADDRESS 2801 Georgia Ave Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Va.		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR OCT 29 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

DMMH 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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7 0 3 0 8 OCT 30 94

02 12 07 80

Case
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H. H. H. H.

Price
New Jersey
H. H. H. H.

CONSTRUCTION

COLLON

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1234

1234

OCT 30 94

069843 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes Marie Smith			2a. DATE OF DEATH MONTH DAY YEAR 10 16 87		2b. HOUR 2:00 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1914		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR Woodward & Lothrop	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Campbell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanny Kube		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-12-1279-A	
17. INFORMANT (Husband) Ray Dudley Smith		18. ADDRESS 19411 Brassie Place #103 Gaithersburg, Md. 20879		19. DATE OF OPERATION 10/15/87		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from 10/15 to 10/16 19 87 that the deceased alive on 10/15 and that in my opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)	
22b. SIGNATURE Byrl D. Johnson		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BYRL D. JOHNSON		22e. ADDRESS 911 N. Russell Ave Gaithersburg, Md. 20879		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/87	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.		25a. DATE REC'D BY REGISTRAR OCT 26 1987	
25b. REGISTRAR'S SIGNATURE John Borden-Randall		25c. REGISTRAR'S NAME John Borden-Randall		25d. REGISTRAR'S ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781		25e. REGISTRAR'S PHONE 4739 1234	

BP

98 52 100 E 4 0 0 3 0

070481 NOV -28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA W. SMITH			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 27 1987			2b HOUR 9:45 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7-16-1932		6 AGE (IN YEARS LAST BIRTHDAY) YRS 55		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) YUGOSLAVIA		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4317 IVY GLEN ROAD 20906	
14 FATHER'S NAME FIRST MIDDLE LAST WEISS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b SOCIAL SECURITY NO. 212-54-4605A			17 INFORMANT ADDRESS LESLIE A. JOHNSON, 4317 IVY GLEN RD. S.S. MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>increased intracranial pressure</u>								1 week	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>malignant melanoma metastatic to brain</u>								2 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from <u>10/27</u> 19 <u>87</u> to <u>10/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Bruce A. Silver</u> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/27/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver						22e ADDRESS 106 IRVING ST. N.W., WASH. DC 20010			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE OCT-30 1987		23c NAME OF CEMETERY OR CREMATORY PARKLAND CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MD		
24 FUNERAL DIRECTOR NAME Tatony Funeral Home, Inc.						25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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OCT 30 1985

068514 OCT 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD P. Smith, JR.			2a DATE OF DEATH MONTH DAY YEAR 10 4 87		2b HOUR 12³⁰ A.M.												
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 2 9 35		6 AGE (IN YEARS LAST BIRTHDAY) 52		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS		7b UNDER 1 YEAR MONTHS DAYS HOURS MIN							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD											
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKBINDER		12b KIND OF BUSINESS OR INDUSTRY HOLLADAY &									
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 10606 S. DUNMOOR DRIVE 20901									
14 FATHER'S NAME FIRST MIDDLE LAST BERNARD P. SMITH, SR.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL POORE				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1957-1959				16b SOCIAL SECURITY NO. 218-30-2816		17 INFORMANT SISTER		ADDRESS 203 GRANVILLE DR. SILVER SPRING, MD 20901	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Bacterial Peritonitis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Cirrhosis with Varicose Bleeding																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 9-30 , 19 87 , to 10-4 , 19 87 that (I) (we) lost saw the deceased alive on 10-3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b SIGNATURE Steven A. Burger, MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-4-87							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Burger, MD						22e ADDRESS 2101 Medical Park Dr. Silver Spring, MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE OCT 7, 1987		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGES MD							
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.						25a DATE REC'D BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez									
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose this certificate in the papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lyle E. Smith Jr.			2a DATE OF DEATH MONTH DAY YEAR October 12, 1987		2b HOUR 3:08 p. m.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 06, 1956		6 AGE (IN YEARS LAST BIRTHDAY) 31 YRS	IF UNDER 1 YEAR MONTHS YEARS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 10407 New Hampshire Avenue 20903
14 FATHER'S NAME FIRST MIDDLE LAST Lyle E. Smith, Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Bateman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b SOCIAL SECURITY NO. 529-92-6672		17 INFORMANT RT.4 Box 366 St. Matthews, S.C. Lyle E. Smith, Sr. (Father) 21935	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acquired Immune Deficiency Syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>3 wks.</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8B, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (1) (this hospital) attended the deceased from <u>Oct 4</u> , 19 <u>87</u> , to <u>Oct 12</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>Oct 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.					
22b SIGNATURE <u>Frank Mayo</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>10-12-87</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank Mayo, M.D.</u>		22e ADDRESS <u>16220 Frederick Road #213</u> <u>Gaithersburg, MD 20877</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>10/17/87</u>	23c NAME OF CEMETERY OR CREMATORY <u>Crestlawn Gardens</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Orangeburg, S.C.</u>
24 FUNERAL DIRECTOR <u>Hines/Rinaldi</u>			25a DATE REC'D BY REGISTRAR <u>OCT 16 1987</u>		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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Col. J. B. Smith

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William W. Smith		2a. DATE OF DEATH MONTH DAY YEAR 10-25-87		2b. HOUR 6:30 P.M.	
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 13 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) H. WILSON HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proof Reader		12b. KIND OF BUSINESS OR INDUSTRY Public. Co.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Rev. Arch C. Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Diggers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 214-10-3064		17. INFORMANT Nancy S. Manis ADDRESS 3055 West Shady Lane Neenah, Wisc. 54956			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Congestive Heart Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 7-1 1987 to 10-25 1987 that (I) (most saw the deceased alive on 10-15 1987 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE John Touben		DEGREE MD		22c. DATE SIGNED 10-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Touben		22e. ADDRESS Bethesda Md. 8218 WISCONSIN AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Front Royal Warren Va.		24. FUNERAL DIRECTOR NAME ADDRESS Maddox Funeral Home, Inc. 105 W Main St Front Royal, Va.			
25a. DATE REC'D BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE Julia Touben-Rudner			

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NOTICE

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST: Emma MIDDLE: Decatur LAST: Snodgrass			2a DATE OF DEATH MONTH: Oct. DAY: 8 YEAR: 1987		2b HOUR 4:22PM M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Sept. 26 1905	6 AGE (IN YEARS LAST BIRTHDAY) 82	7 UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	
7a BIRTHPLACE (STATE OR FOREIGN) Virginia	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY own home	
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME Murry C. Decatur			15 MOTHER'S MAIDEN NAME Lillian Ada Talmage		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) N/A (IF YES, GIVE YEAR DATES) N/A		16b SOCIAL SECURITY NO 220-46-6314	17 INFORMANT Shirley S. Howell-daughter- (same as 13e)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis-infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>arteriosclerotic heart disease, atrial fibrillation</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (the deceased) attended the deceased from 19 <u>86</u> to <u>10-8</u> 19 <u>87</u> that (1) last saw the deceased alive on <u>10-7</u> 19 <u>87</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above; (2) (I) did (I) view the body after death					
22b SIGNATURE <u>G. Sengstack, MD</u>				22c DATE SIGNED 10-8-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) G. Sengstack, MD				22e ADDRESS 3929 Ferrara Drive, Wheaton, Maryland	
23a BURIAL CREMATION REMOVAL (SPECIFY) Burial	23b DATE 10-9-1987	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION Brentwood Pr. Georges Md.		
24 FUNERAL DIRECTOR Hine, Rinaldi Funeral Home 1800 N.H. Ave., Silver Spring, Md.			25a DATE RECD. BY REGISTRAR OCT 13 1987		
25b REGISTRAR'S SIGNATURE <u>Julia Friedman-Randall</u>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove and retain pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB M. SOKOL			2a DATE OF DEATH MONTH DAY YEAR 10-19-87		2b HOUR 9 30 M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 23, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b KIND OF BUSINESS OR INDUSTRY Grocery Industry	
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Sokol		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Berkowitz			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Joel Stearman, Nephew; 8506 Wild Olive Drive; Potomac, Md. 20854	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular Accident years. DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE Atherosclerosis years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) this hospital attended the deceased from 6-17 19 82 to 10-19 19 87 that (I) (we) last saw the deceased alive on 10-19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b SIGNATURE Loreto A. Albino		DEGREE MD		22c DATE SIGNED 10-20-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Loreto ALBINO		22e ADDRESS 6121 MONTROSE Rd.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/22/87	23c NAME OF CEMETERY OR CREMATORY Washington Hebrew Mem. Pk.		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		ADDRESS 1170 Rockville Pike; Rockville, Md. 20852		25a DATE RECEIVED BY REGISTRAR OCT 23 1987	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. This permit must have carbon copies pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only medical or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ESTHER C. SOLOMON			2a. DATE OF DEATH MONTH DAY YEAR 10/28/87		2b. HOUR MIN 8:10 A
3 SEX FEMALE	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11/4/09		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE COUNTRY: RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1121 University Blvd., W #816 (20902)
14 FATHER'S NAME FIRST MIDDLE LAST Max Feldman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Rachel Pinchuk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 578-22-3942		17 INFORMANT ADDRESS Bethesda, Md. 20817 Dr. Herbert Solomon; Son; 7505 Marbury Road;	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiopulmonary arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hypercalcemia					2 months
DUE TO, OR AS A CONSEQUENCE OF (c) advanced bladder cancer					7 months
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/28 10/7 19 87 to 10/28 19 87 that (I) (we) lost saw the deceased alive on 10/28 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not view the body after death.					
22b. SIGNATURE Bruce A. Silver		DEGREE MD		22c. DATE SIGNED 10/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver		22e. ADDRESS 106 PARK ST., NW WASH DC 20010			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 10/30/87	23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cong. Cemetery, Capitol Heights, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE REC'D BY REGISTRAR NOV 2 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rudace	
1170 Rockville Pike; Rockville, Md. 20852					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Letter C. [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

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[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANASTASIA C. SOUPOURAS			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 20, 1987		2b HOUR 8:15 A M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 25, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREECE	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2508 JENNINGS COURT		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MARYLAND		13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN COLGIS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN COZANAS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-42-7127		17 INFORMANT DAUGHTER ADDRESS 10808 HOBSON ST. KENSINGTON, MD 20895	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) atherosclerotic cardiovascular disease					13 years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 3 OR PART 2)	
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from July 1, 1983 to October 20, 1987 , that (I) was last saw the deceased alive on Sept 17, 1987 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.					
22b SIGNATURE <i>Michael Lincoln</i>		DEGREE		22c DATE SIGNED 10/20/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL LINCOLN, MD		22e ADDRESS 10313 66th Ave Suite 308 Silver Spring MD 20902			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT23,1987		23c NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	
23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a DATE REC'D BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <i>John Anderson-Hendall</i>	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					

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01-1010-1844

10/10/18

W. W. W.

0012384

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

37 30139

1 DECEASED NAME (TYPE OR PRINT) GORDON WAYNE SPRAY			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 1 1987			2b HOUR 2:33 A M			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR AUGUST 25 1949		6 AGE (IN YEARS LAST BIRTHDAY) 38 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
13a STATE VIRGINIA		13b COUNTY FAIRFAX		13c CITY OR TOWN SPRINGFIELD		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 7940 JANSEN DRIVE 22152	
14 FATHER'S NAME FIRST MIDDLE LAST WAYNE SPRAY				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SELMA COCHRAN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 1973-1987		17 INFORMANT SELMA ALEXANDER, 10310-A LURIA COMMONS COURT,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) METASTATIC LUNG CARCINOMA DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART I OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 8 19 87 to OCTOBER 1 19 87 , that (I) (we) last saw the deceased alive on OCTOBER 1 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE S.G. Fellowes DEGREE MD						22c DATE SIGNED 1 OCT 87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) S.G. Fellowes, LT, MC, USNR						22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 29/12/87		23c NAME OF CEMETERY OR CREMATORY Everly F H Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.		
24 FUNERAL DIRECTOR NAME Everly Funeral Home 10565 Main St Fairfax, Va.						25a DATE RECD BY REGISTRAR 05 1987 25b REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certain powers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or filled, it shows any injury, or other traumatic event, the medical examiner must be notified at once.
DHMH - 16 (06A) 7/84 (VRA 15, 4)

065545 OCT-581

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WILLIAM TRIPLETT SPIEGEL		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 30 1987		2b. HOUR 10:42 A M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JULY 4 1917		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Relations. Officer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE VIRGINIA 13b COUNTY FAIRFAX 13c CITY OR TOWN SPRINGFIELD		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE CLIFFORD SPIEGEL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH TRIPLETT		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1941-1962		17 INFORMANT ADDRESS TERESA A. SPIEGEL, 6725 HACKBERRY STREET, SPRINGFIELD, VA 22150
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 5)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 29</u> 19 <u>87</u> to <u>OCTOBER 30</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>OCTOBER 30</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Edward P. Fox		DEGREE MD		22c DATE SIGNED 02 Nov 87
22d PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT, MC, USN		22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 11-2-87	23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc.		25a DATE REC'D. BY REGISTRAR NOV 06 1987		
P. O. Box 43352, Washington, DC 20010		25b REGISTRAR'S SIGNATURE Julia Anderson-Randall		

1103 NOV-80

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gloria H. Stanley			2a DATE OF DEATH MONTH DAY YEAR 10 23 87			2b HOUR 2:40 PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR AUG. 24, 1921		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 66	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH Swan Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN		12b KIND OF BUSINESS OR INDUSTRY P.G.CO. Public School	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY P.G.CO.		13c CITY OR TOWN ADELPHI		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1743 KEDDIE ST. / 20783		
14 FATHER'S NAME FIRST MIDDLE LAST ABNER LAURIE HEISLER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GWENDOLYN AMELIA JONES			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE			16b SOCIAL SECURITY NO 215-18-8822		
17 INFORMANT KERRY D. STANLEY			ADDRESS 286 SHINGOWACK TRAIL MEDFORD LAKES NEW JERSEY								

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last b) intermittent lung disease DUE TO, OR AS A CONSEQUENCE OF c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from 2 19 87 to 10/23 19 87 that (1) (we) last saw the deceased alive on 10/23 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did not) view the body after death							
22b SIGNATURE Jay Weiner				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner				22e ADDRESS 4701 Randolph Rd Rockville, MD			

23a BURIAL CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCTOBER 26, 1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.CO. MARYLAND	
24 FUNERAL DIRECTOR NAME ADDRESS W.W. CHAMBERS CO., INC. 2655 GEORGIA AVE. SWANSPRING MD				25a DATE REC'D BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE Julia Friedman-Pendue	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

05063101-50

Glenn H. Stanley
10 23 41

From: [illegible] and [illegible]

Re: [illegible]

Enclosed for the [illegible]

Enclosed for the [illegible]

Enclosed for the [illegible]

Enclosed for the [illegible]

Enclosed for the [illegible]

Enclosed for the [illegible]

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Enclosed for the [illegible]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7 B4
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William W Stephenson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-5-87</i>		2b. HOUR P M <i>6:16 P M</i>		
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6-06-02</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN <i>85</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Minister</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Baptist Church</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Fairmont Hgts</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>843 Eastern Ave 20743</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>William W. Stephenson Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca Unk</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>578-09-0654</i>		17. INFORMANT (Wife) <i>Ella L. Stephenson.</i>		17. ADDRESS <i>843 Eastern Ave. 20743.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic renal failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8/24 1987</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>87 10/5 1987</i>		21g. I certify that (I) (this hospital) attended the deceased from <i>8/24</i> 19 <i>87</i> to <i>10/5</i> 19 <i>87</i> that (I/we) last saw the deceased alive on <i>8/24</i> 19 <i>87</i> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did/did not) attend the body after death.		22a. SIGNATURE <i>Myron L. Lenkin</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MYRON L. LENKIN</i>		22c. ADDRESS <i>2309 SHOREFIELD RD WHEATON MD</i>		22d. DATE SIGNED <i>10/5/87</i>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10-7-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>U. William Lee's Sons Company 300 4th St N.E. Washington, D.C. 20002</i>				25a. DATE REC'D BY REGISTRAR <i>OCT 8 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30143

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA ANN STEWARD			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 3 1987		2b HOUR 1:10 A M
3 SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 8 1943		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE At Home		12b KIND OF BUSINESS OR INDUSTRY Housewife
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY VIRGINIA Prince William			13b CITY OR TOWN WOODBIDGE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST JAMES CHARLES MCDONALD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH STODNIK		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 044-34-0356		17 INFORMANT ADDRESS ROGER E STEWARD 12037 Stoneford DR. WOODBRIDGE VA 22192	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 29, 19 87, to OCTOBER 3, 19 87, that (I) (we) last saw the deceased alive on OCTOBER 3, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE TERRENCE DWYER LT MC USN				22c DATE SIGNED 4 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) TERRENCE DWYER LT MC USN				22e ADDRESS NAVAL HOSPITAL, BETHESDA MD 20814-5011	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 5, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		24 FUNERAL DIRECTOR NAME ADDRESS Mountcastle Funeral Home 13318 Occoquan Road Woodbridge, VA 22191			
25a DATE REC'D. BY REGISTRAR OCT 07 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH M. STONE		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 27 1987		2b. HOUR 3:15 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7, 1893	
6. AGE (IN YEARS (LAST BIRTHDAY)) 94		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Rockville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stady Grove Adventist Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Map Service		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1930 Club House Rd./20879		14. FATHER'S NAME FIRST MIDDLE Charles Marks	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE Freda Jonhson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 577-36-9428	
17. INFORMANT Lloyd L. Stone, Same address as #13.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aspiration DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's disease DUE TO, OR AS A CONSEQUENCE OF (c) decelerate		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. decelerate					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 9/25 , 19 87 , to 10/27 , 19 87 that (I) (we) last saw the deceased alive on 10/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE John R. Melnick		DEGREE MD		22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Melnick		22e. ADDRESS 911 Russell Ave. Gaithersburg, MD 20879			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016			
25a. DATE REC'D BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

069031 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MaBELLE V. Stott			2a DATE OF DEATH MONTH DAY YEAR October 13, 1987		2b HOUR 1:55PM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 17, 1905		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home				
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		
14 FATHER'S NAME FIRST MIDDLE LAST Don E. Vanice		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Busey		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578-14-0365		17 INFORMANT Don S. Stott 2801 North College Drive Durango, Colorado 81301 (Son)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: b) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one month many years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22 I certify that (I) (this hospital) attended the deceased from November 26, 1980 to October 13, 1987 that I (we) last saw the deceased alive on September 18, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE James E. Wilson M.D.		DEGREE MD		22c DATE SIGNED 10/13/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) James E. Wilson, M.D.		22e ADDRESS 11125 Rockville Pike, Rockville, Md. 20852				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE October 14, 1987		23c NAME OF CEMETERY OR CREMATORY Crematorium Inc.		
23d LOCATION CITY OR TOWN COUNTY STATE Bethesda Maryland		24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 20814 Avenue Bethesda, Maryland				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The attending physician and funeral director must remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

068157 OCT-1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) SHEILA DOROTHEA MARY STRICKLAND			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 5 1987			2b HOUR 1:02 P _M					
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR MARCH 24 1944		6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 7 UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE COUNTRY ENGLAND		7b CITIZEN OF WHAT COUNTRY? ENGLAND		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE MARYLAND			13b COUNTY PRINCE GEO'S		13c CITY OR TOWN TEMPLE HILLS		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6502 ACORN COURT 20748		
14 FATHER'S NAME FIRST MIDDLE LAST LOUIS HENRY MARTIN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CYNTHIA COLE							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -			16b SOCIAL SECURITY NO 372-48-1976		17 INFORMANT ADDRESS JAMES E. STRICKLAND, 6502 ACORN COURT,						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA METASTATIC TO BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 22</u> 19 <u>87</u> , to <u>OCTOBER 5</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 5</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>L. R. Lovell</i>					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) L. R. LOVELL, LCDR. MC, USN					22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011						
23a BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b DATE 10/09/87		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem			23d LOCATION (CITY OR TOWN) Arlington		23e COUNTY Virginia	
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.					25a DATE REC'D. BY REGISTRAR OCT - 8 1987			25b REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			
6633 Old Alexander Ferry Rd Clinton, Md 20735											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1 DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
RALPH LEROY SULLIVAN2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
10/18/87 11 PM

3 SEX

MALE

4 RACE

White

5 DATE OF BIRTH

MONTH DAY YEAR
12/6/01

6 AGE (IN YEARS LAST BIRTHDAY)

85 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

D.C.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD

10 CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Washington Adventist Hospital

12a USUAL OCCUPATION

Retired dispatcher

12b KIND OF BUSINESS OR INDUSTRY

Oil Company

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

Silver Spring, Md. 20903

13e STREET ADDRESS, ZIP CODE
10120 New Hampshire Ave. #102

14 FATHER'S NAME

John

MIDDLE

T.

LAST

Sullivan

15 MOTHER'S MAIDEN NAME

Daisy

MIDDLE

Bremerman

LAST

Bremerman

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

YES ☒ NO ☐ UNKNOWN ☐

16b SOCIAL SECURITY NO.

1922-1932

16c SOCIAL SECURITY NO.

578-10-6199

17 INFORMANT

Silver Spring, Md. 20904
Patricia A. Frank (daughter) 1360 Elm Grove Circle18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerosis general

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Pulmonary Embolism

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 9 OCT 87 to 13 OCT 87 that (I) (we) lost
saw the deceased alive on 13 OCT 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

19 OCT 87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Thomas P. Fogarty

22e ADDRESS

7676 New Hampshire Ave. Langley Pk, Md.

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10/21/87

23c NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

23d LOCATION

Brentwood, Maryland

STATE

24 FUNERAL DIRECTOR

Tyson Wheeler Funeral Home, Inc.

1331 Rockville Pike, Rockville, Md. 20852

25a DATE REC'D. BY REGISTRAR

OCT 23 1987

25b REGISTRAR'S SIGNATURE

Julia Swanson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as such, any injury, or other traumatic event, the medical examiner must be notified at once.

68773 02128 61

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068510 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please place carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7:14
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Andreis — Talbergs		2a DATE OF DEATH MONTH DAY YEAR 10-3-87		2b HOUR 2²⁹ M	
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR NOVEMBER 6, 1897	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) LATVIA		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS (LAST BIRTHDAY)) YRS MONTHS DAYS 89	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b KIND OF BUSINESS OR INDUSTRY LATVIAN CIVIL		13a STREET ADDRESS / ZIP CODE 1224 KATHRYN ROAD 20904	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1224 KATHRYN ROAD 20904		13f SERVICE SERVICE	
14 FATHER'S NAME FIRST MIDDLE LAST JANIS — TALBERGS		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE — ZILEVICS		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 066-36-4607		17 INFORMANT ADDRESS ALDA T. WHITT/DAUGHTER/SAME AS 13		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Left Sig. Angiogram Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 20 1/2 centimeter (c) —	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Cholesterol					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 9/19/87 19 87 to 10/3 19 87 that (I) (we) last saw the deceased alive on 9/19/87 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
21f SIGNATURE Francis J. Collins		DEGREE MD		22c DATE SIGNED 10/3/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS J. COLLINS, M.D.		22e ADDRESS 8808 HEDDER HILL LANE - BOWIE			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE OCT 7, 1987		23c NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			
25a DATE REC'D BY REGISTRAR OCT 13 1987		25b REGISTRAR'S SIGNATURE John Decker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (Type or Print)		FIRST FLORENCE		MIDDLE TALBERT		LAST TALBERT		2a. DATE OF DEATH MONTH DAY YEAR		10/14/87		2b. HOUR 1 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept 8 1897		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? Usa		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WILSON HEALTH CARE CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Asbury Methodist Village 20760		14 FATHER'S NAME FIRST MIDDLE LAST Charles Alexander Talbert		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Virginia Hanson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 213-28-2417		17 INFORMANT Richard E. Talbert 1010 S. Carroll St. 21074		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (i) (the deceased) attended the deceased from <u>7-1</u> 19 <u>87</u> to <u>10-14</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>10-14</u> 19 <u>87</u> , and that in (my) <u>no</u> opinion death occurred on the date and hour and from the causes stated above, (i) (I) (did) (did not) view the body after death.		22b SIGNATURE <u>John Tauber</u>		DEGREE MD		22c DATE SIGNED 10-14-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e ADDRESS 8218 Wisconsin Ave		22f PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22g ADDRESS 8218 Wisconsin Ave		22h PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22i ADDRESS 8218 Wisconsin Ave		22j PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-17-87		23c NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Owings Mills Balto. Md.		24 FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md.		25a DATE REC'D. BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE John Tauber	

0 6 2 5 2 6 (CCT 5) 17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 - DECEASED NAME (LAST OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
Mildred		P.		Talman	10	26	87		12:20AM
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female	White		April 26 1905		82				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Penn.	USA				Montgomery MD				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Olney	Montgomery General Hospital				Homemaker				
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	14 STREET ADDRESS / ZIP CODE					
Md.	Mont.	S.S.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10921 Inwood Avenue 20902					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Howard S. Patterson		Emma Nitzenberger							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
N/A		171 16 5602A		Mary Ann Suman-Friend 206 Osceola Drive New Port Richey, Fla.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									1 month
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u>									6 years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Urinary Tract Infection</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Primary lateral Sclerosis, Spastic bladder, Impair, Osteoporosis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22 I certify that (i) (the hospital) attended the deceased from 19 <u>87</u> to <u>10/26</u> 19 <u>87</u> that (i) (we) last saw the deceased alive on <u>10/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did not) view the body after death.									
22b SIGNATURE		DEGREE		22c DATE SIGNED					
Oliver J. Lawless MD				10/26/87					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
Oliver J. Lawless		3801 International Drive Silver Spring 20906							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY	STATE
Burial		Oct. 29, 1987		Arlington Cemetery		Drexel Hill, Penn.			
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.				OCT 27 1987		Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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5% COTTON IMPROVED

1000 62005

068350 OCT

387 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Antoinette C. Tamburino		2a. DATE OF DEATH MONTH 10 DAY 5 YEAR 87		2b. HOUR 5 P M	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH 7 DAY 09 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK CITY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4011 Randolph Road/20902
14. FATHER'S NAME FIRST Anthony MIDDLE Prozzo LAST Prozzo		15. MOTHER'S MAIDEN NAME FIRST Carmella MIDDLE --- LAST Colesante			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 120-22-1253		17. INFORMANT Elissa O. McGuire, Potomac, MD 20854	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a CHRONIC ORGANIC BRAIN SYNDROME / DEMENTIA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if in this hospital) attended the deceased from 1/14 19 85 to 10/5 19 87 that (if not) saw the deceased alive on 9/9 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did) did not view the body after death.					
22b. SIGNATURE Martin C. Shargel		DEGREE M.D.		22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL		22e. ADDRESS 3720 FALLACUT AVE KEESINGTON MD 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/7/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		23e. DATE REC'D BY REGISTRAR OCT 09 1987			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		25a. DATE REC'D BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE Lia Gordon-Randall	
5130 Wisconsin Ave, NW, Washington, D.C. 20016					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial transit permit. Thereafter, it may be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury as traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 showing injury or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		Item 1, 15, Film G633 11-10-87 I.J.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		87 30152			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick B. M. Taylor				2a DATE OF DEATH MONTH DAY YEAR 10/28/87				2b HOUR 9:30 AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 1 18 15		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF BINDER 1 YEAR IF BINDER 1 HR	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a USUAL OCCUPATION Vice President		12b KIND OF BUSINESS OR INDUSTRY Thomas Somerville Supply			
13a STATE Md.		13b COUNTY NAT		13c CITY OR TOWN Beverly Beach		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS & ZIP CODE 226 Maryland Avenue 21106	
14 FATHER'S NAME FIRST MIDDLE LAST Charles H. Taylor				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Floa C. MacLeod					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b SOCIAL SECURITY NO. 578 07 1338A		17 INFORMANT 9801 50th Place College Park, Md. Jacqueline A. Clark (Daughter)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Septic DUE TO, OR AS A CONSEQUENCE OF (c) Bacteremia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes mellitus									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from 7-1 1987 to 10-28 1987 that (I) lost saw the deceased alive on 10-28 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (didn't) view the body after death.									
22b SIGNATURE John Taylor				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10-28-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John Taylor				22e ADDRESS Bethesda Md. 8218 Wisconsin Ave					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood PG Md.		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.				25a DATE REC'D BY REGISTRAR NOV 3 1987		25b REGISTRAR'S SIGNATURE Hines/Rinaldi			

United States of America

State of

County of

City of

NOV 2 1987

NOV 2 1987

NOV 2 1987

NOV 2 1987

NOV 2 1987

NOV 2 1987

NOV 2 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

GRACE ELIZABETH TAYLOR

2a DATE OF DEATH

MONTH

DAY

YEAR

OCTOBER 15 1987

7b HOUR

11:25 A M

3 SEX

FEMALE

4 RACE

BLACK

5 DATE OF BIRTH

MONTH

DAY

YEAR

MARCH 2 1959

6 AGE (IN YEARS LAST BIRTHDAY)

28

IF UNDER 1 YEAR

IF UNDER 1 YEAR

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

LOUISIANA

7b CITIZEN OF WHAT COUNTRY?

UNITED STATES

8 MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD

10 CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

NAVAL HOSPITAL

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

STUDENT

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

PRINCE GEO'S

13c CITY OR TOWN

TEMPLE HILLS

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

5974 FISHER ROAD 20748

14 FATHER'S NAME

FIRST

MIDDLE

LAST

HERBERT ISRAEL TAYLOR

15 MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

AUDREY HOLMES

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

-

17 INFORMANT

434-17-9302

ADDRESS

AUDREY H. TAYLOR, 5974 FISHER ROAD, TEMPLE HILLS

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) MYCOSIS FUNGOIDES

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) SEPSIS AND ADULT RESPIRATORY DISTRESS SYNDROME

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☒ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☒ NO ☐

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from SEPTEMBER 28, 19 87 to OCTOBER 15, 19 87, that (I) (we) last
saw the deceased alive on OCTOBER 15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c DATE SIGNED

15 Oct-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

EDWARD P. FOX, LT, MC, USNR

22e ADDRESS

NAVAL HOSPITAL

BETHESDA, MD 20814-5011

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10/17/87

23c NAME OF CEMETERY OR CREMATORY

Montz Memo. Park

23d LOCATION

Montz, Louisiana

STATE

24 FUNERAL DIRECTOR

Robottom Mortuary

2700 Jefferson Hwy. Reserve, LA. 70084

25a DATE REC'D. BY REGISTRAR

OCT 19 1987

25b REGISTRAR'S SIGNATURE

Julia Davis-Rubens

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

000118 OCT 30 64

ALTON H. HENRY

Alton H. Henry

Alton H. Henry

068316 OCT 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30154
2a DATE OF DEATH MONTH DAY YEAR 10 6 87 2b HOUR 8:18 AM1 DECEASED NAME FIRST MIDDLE LAST
RUTH Imogene TAYLOR3 SEX
Female4 RACE
White5 DATE OF BIRTH
MONTH DAY YEAR
may 5 19046 AGE (IN YEARS LAST BIRTHDAY)
83 YRS.IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Oklahoma7b CITIZEN OF WHAT COUNTRY?
USA8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD10 CITY OR TOWN OF DEATH
Rockville11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Hospital12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker12b KIND OF BUSINESS OR INDUSTRY
Home13a STATE
Maryland13b COUNTY
Montgomery13c CITY OR TOWN
Olney13d INSIDE CITY LIMITS?
YES ☐ NO ☒13e STREET ADDRESS / ZIP CODE
19109 Bloomfield Road 2083214 FATHER'S NAME
FIRST MIDDLE LAST
David Diehl15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Imogene Wetmore16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no16b SOCIAL SECURITY NO.
515-38-904417 INFORMANT ADDRESS
Jerry Wheeler Olney, Maryland18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last }
(b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of uterus

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?
YES ☐ NO ☒20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)21f LOCATION
CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 19 86 to 10 16 19 87 that (we) last saw the deceased alive on 10 5 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

22b SIGNATURE
JOHN G. LODMELL MDDEGREE
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐22c DATE SIGNED
10/6/8723a PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN G. LODMELL22e ADDRESS
201 OLNEY-SANDY SPRING RD.
OLNEY MD 2083223a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial23b DATE
October 10, 198723c NAME OF CEMETERY OR CREMATORY
MT. HOPE Cemetery23d LOCATION
CITY OR TOWN COUNTY STATE
INDEPENDENCE MONTGOMERY Kansas24 FUNERAL DIRECTOR
NAME
Barber Funeral Home, Laytonsville, Md. 2087925a DATE RECEIVED BY REGISTRAR
OCT 09 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 16 60M 7/84
(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

080310 OCT 13 85

080310 OCT 13 85

068768 OCT 18 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doris R Teras			2a DATE OF DEATH MONTH DAY YEAR 10 8 87		2b HOUR 11:42pm
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 01 09 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Olney	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Montgomery		
13c CITY OR TOWN Gaithersburg			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Harry -- Whittaker			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa -- Bartley		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no		16b SOCIAL SECURITY NO. 029-01-4144		17 INFORMANT ADDRESS same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Liver failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic cancer DUE TO, OR AS A CONSEQUENCE OF (c) squamous cell carcinoma of cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1 mo 4 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Radiation Colitis. Post Stage I Breast Cancer on left					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from 10/8/87 to 10/18/87 that (I) (we) saw the deceased alive on 10/8/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Donald E. Dillon M.D.		DEGREE M.D.		22c DATE SIGNED 9 Oct 87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.		22e ADDRESS 2901 Olney-Sandy Spring Rd. Olney, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 9, 1987		23c NAME OF CEMETERY OR CREMATORY Balto./Wash. Crem.	
23d LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Maryland					
24 FUNERAL DIRECTOR NAME ADDRESS MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a DATE REC'D. BY REGISTRAR OCT 15 1987			
25b REGISTRAR'S SIGNATURE John D. Barber					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the proper place. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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00078 OCT 18 81

69144

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the registration card (page 1) and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REGINALD FRANKLIN THACKER					2a. DATE OF DEATH MONTH DAY YEAR 10 11 87				
3. SEX MALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 27 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7b. HOUR 6:40 AM	
7a. BIRTHPLACE (COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2119 Chapman Rd. 20783	
14. FATHER'S NAME FIRST MIDDLE LAST Burton Adolphus Thacker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esma Drummond					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 228-01-2935		17. INFORMANT ADDRESS Betty Croft Thacker Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) diabetes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-27-87 to 10-11-87 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M SNOW MD				DEGREE MD				22c. DATE SIGNED 10.11.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD				22e. ADDRESS 9013 FLOWER AVE SILVER SPRING MD 20901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gordonsville Orange Virginia			
24. FUNERAL DIRECTOR NAME Predy Funeral Home				ADDRESS PO Box 214 Gordonsville		25a. DATE REC'D BY REGISTRAR OCT 14 1987			

MEDICAL CERTIFICATION

0211 OCT 20 81

13-03700 82106

70350 OCT 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-BM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30150

FOR
1- STATE
REGISTRAR

REG NO

1 DECEASED NAME (PRINT) LEO P. TOUMA			2a DATE KNOWN OF DEATH X OF ESTI MATED 10 21 19 87		2b HOUR M 6:51 A M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR MAR 11, 1935	6 AGE (IN YEARS) (LAST BIRTHDAY) 52 YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		10 CITY OR TOWN OF DEATH Silver Spring			
11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) front of 733 Sligo Ave.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL		12b KIND OF BUSINESS OR INDUSTRY HECHT CO.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 612 GIST AVENUE 20910	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH P. TOUMA			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAZIRA ASWAD		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 579-52-0370		17 INFORMANT ADDRESS NAZIRA TOUMA/MOTHER/SAME AS 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:45xx 10-21- 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pedestrian struck by auto.	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) street		21f LOCATION STREET CITY OR TOWN COUNTY STATE 733 Sligo Ave., Silver Spring, Montgomery, MD	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief		DATE SIGNED 10-21-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT24,1987		23c NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	
23d LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			
25a DATE REC'D BY REGISTRAR OCT 29 1987		25b REGISTRAR'S SIGNATURE 			

07-84
25M

BP

DHMH: 17
(VR A15 ME (5))

10350 OCT 20 21



RECEIVED OCT 20 21

DAVID

WILKINSON

10350 OCT 20 21

068327 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30159

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCIE C. TOURNEUR			2a. DATE OF DEATH MONTH DAY YEAR 10.3.87		2b. HOUR 09:00 am		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 27, 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FRANCE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY MACHINE TOOL	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EUGENE - TOURNEUR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUSTINE - RUSE		13e. STREET ADDRESS / ZIP CODE 882 COLLEGE PARKWAY #204 / 20850			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 477-44-0491A		17. INFORMANT MONIQUE HAFREY (DAUGHTER)		ADDRESS 7008 AMY LANE BETHESDA, MD. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VERY ADVANCED CHF DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED DILATED CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) CHROM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUB AKE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 18th St. 30th St. 97			
22a. I certify that (1) this hospital attended the deceased from 10/2/87 to 10/3/87 that (2) I last saw the deceased alive on 10/2/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)							
22b. SIGNATURE MONIQUE HAFREY				22c. ADDRESS 17904 GORDON AVE OLNEY, MARYLAND 20932			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONIQUE E. DODLEY MD				22e. ADDRESS 17904 GORDON AVE OLNEY, MARYLAND 20932			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE OCT. 6, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGCO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MARYLAND				25a. DATE REC'D BY REGISTRAR OCT 09 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

000351 OCT 1961

10-2-51

11-11-61

To: Mr. J. Edgar Hoover

From: Mr. J. Edgar Hoover

Subject: [Illegible]

Reference: [Illegible]

Enclosure: [Illegible]

Very truly yours,

[Illegible Signature]

[Illegible Title]

[Illegible Address Line 1]

[Illegible Address Line 2]

[Illegible Address Line 3]

[Illegible Address Line 4]

[Illegible Address Line 5]

[Illegible Address Line 6]

[Illegible Address Line 7]

[Illegible Address Line 8]

[Illegible Address Line 9]

OCT 08 1961

070025 OCT 28 87

OR
- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b HOUR							
John			Harry			Trout			10-22-87			M							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		2d HOUR					
Male		White		Oct. 16, 1953		34 YRS						10-23 1987		12:20 A M					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Montgomery County MD							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY							
Rockville				Shady Grove Adventist Hospital				Manager-				Meat Market							
13a STATE												13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS	
Maryland												Carroll		Mt. Airy		YES		3013 Michael Rd. 21771	
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Harry O. Trout						Mary Anne Clayton													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b SOCIAL SECURITY NO.						17 INFORMANT ADDRESS							
No						212-66-8024						Vicki Lynn Trout, Item 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Thoraco-abdominal injuries																			
8170 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				11:10 PM 10-22-87				Driver in auto/auto collision											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)				21f LOCATION											
				road				Route 27 and 80, Kemptown, Montgomery Co., MD											
22a I certify that I have viewed the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED							
Charles P. Kokes, M.D.						Assistant MEDICAL EXAMINER						10-23-87							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS													
Charles P. Kokes, M.D.						111 Penn Street, Baltimore, MD 21201													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE									
Burial				Oct. 26, 1987		Parklawn				Rockville, Montgomery, Md.									
24 FUNERAL DIRECTOR NAME						25a DATE REC'D BY REGISTRAR						25b REGISTRAR'S SIGNATURE							
Olin L. Molesworth, P.A., Damascus, Md.						OCT 27 1987													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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20% COTTON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILA JOHNSON TUCKER			2a. DATE OF DEATH MONTH DAY YEAR 10 - 4 - 87		2b. HOUR MIN. 1415 M		
3. SEX FEMALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 1 15 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NB		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD.		13b. COUNTY WHEATON		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK.			
16b. SOCIAL SECURITY NO. 357-20-0159		17. INFORMANT KENNETH TUCKER		ADDRESS - 942-3190			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA PSIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21B, PART 2 OR PART 3)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/10/87 19 to 10/3 19 87 that (I) (we) lost saw the deceased alive on 10/3/87 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE		22c. DATE SIGNED 10/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELSA J. MARTINEZ, MD.				22e. ADDRESS 8808 Hudson Ave LA. POTOMAC, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-4-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 07 1987	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

106-100 77852

COPIES

106-100 77852

106-100 77852

070911 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HARRY WILLIAM TURNER			2a DATE OF DEATH MONTH DAY YEAR 10/20/87			2b HOUR 1015 AM			
3 SEX MALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR July 19, 1911		6 AGE (IN YEARS) BIRTHDAY 76		7 MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1135 University Blvd West				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.			13b COUNTY Montg		13c CITY OR TOWN Wheaton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST HARRY TURNER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Copeland			13e STREET ADDRESS / ZIP CODE 1135 Univ. Blvd West #402 20902			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 077-07-0933		17 INFORMANT ADDRESS Della Douglas (daughter) 2101 Pritchard Wheaton, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ESOPHAGEAL CARCINOMA								3 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AS WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (the hospital) attended the deceased from July 6, 1987 to October 20, 1987 that (1) (the) last saw the deceased alive on September 30, 1987 , and that in my opinion death occurred on the date and hour and from the causes stated above, (1) (I) (did not) view the body after death.									
22b SIGNATURE George Bolan						DEGREE M.D.		22c DATE SIGNED 10/20/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE BOLAN, M.D.						22e ADDRESS 9711 MEDICAL CENTER DRIVE, #308 ROCKVILLE MD 20850.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-23-87		23c NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Boyd's, Montg. Co., MD		
24 FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850						25a DATE REC'D BY REGISTRAR OCT 26 1987		25b REGISTRAR'S SIGNATURE George R. Snowden	

07011 OCT 20

1. The first part of the report is a general
description of the project. It includes a
brief history of the project and a statement
of the purpose of the study. The second part
of the report is a description of the methods
used in the study. This includes a description
of the subjects, the materials, and the
procedures. The third part of the report is
a description of the results of the study.
This includes a description of the data and
the statistical analysis. The fourth part of
the report is a discussion of the results.
This includes a comparison of the results
with previous studies and a discussion of the
implications of the findings. The fifth part
of the report is a conclusion. This includes
a summary of the findings and a statement
of the limitations of the study.

069816 OCT 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30163

FOR
STATE
REGISTRAR

REG. NO.

1. BASED NAME (PRINT) Gladys Mae Tuttle		2a. DATE KNOWN OF DEATH MONTH DAY YEAR Oct 21 1987		2b. HOUR 1:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov 23 1929	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	IF UNDER 1 YR MONTHS DAYS 0 0	IF UNDER 24 HRS HOURS MIN 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Greenup		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Academy Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Kentucky		13b. CITY OR TOWN Raceland		13c. STREET ADDRESS 620 Chinn Street #1169	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred -- Rice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minta -- Lewis		16. SOCIAL SECURITY NO. 233-90-4205	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		17b. INFORMANT Robert Tuttle, Chantilly, VA 22021		17c. ADDRESS 13511 King Charles Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep.		DATE SIGNED Oct 21 1987	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Montgomery Co., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit		23b. DATE 10/22/87		23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D. BY REGISTRAR OCT 26 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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DHMH - 17
(VR A15 ME (5))

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Little

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Allyne

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White

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BY

Even Home

Homemaker

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No. 100

Leads

Auto

Price

Alfred

1911 King Charles St.

Robert Apple, Chantilly, VA 22021

57-90-1508

No



Silver Spring, Montgomery Co., MD

John S. Rogers

Asland, Boyd Co., KY

Asland Cemetery

OCT 25 1981

Joseph Taylor's Sons, Inc.
2150 Macdonald Ave., Washington, D.C. 20024

070639 NOV-30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30104

1 DECEASED NAME (TYPE OR PRINT) ELIZABETH F. Twombley			2a DATE OF DEATH MONTH DAY YEAR 10-26-87			2b HOUR 6:30 PM			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 1, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH WHEATON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR CARE NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST THOMAS O. WHITE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-18-9995		17 INFORMANT ADDRESS WILLIAM F. TWOMBLEY/HUSBAND/SAME AS 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 36 PART 3 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 10/16/87 to 10/26/87 that (I) last saw the deceased alive on 10/26/87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Myron L. Lenkin				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10/27/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN				22e ADDRESS 2309 SHOREFIELD RD WHEATON, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE OCT29,1987		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGES MD			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a DATE REC'D BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE [Signature]			

BP

ELIZABETH R. TWENTY-THREE

1930-1931

1931-1932

1932-1933

1933-1934

1934-1935

1935-1936

1936-1937

1937-1938

1938-1939

1939-1940

1940-1941

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

068699 OCT 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kazimiera Ullmann			2a. DATE OF DEATH MONTH DAY YEAR October 09, 1987		2b. HOUR 8:25a M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? Poland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS / ZIP CODE 7826 Heatherton Lane 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 061-28-4651		17. INFORMANT ADDRESS Adele A. Ullman Potomac, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 20 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Aortic Stenosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital)) attended the deceased from 11-24-1972 to 10-9-1987 that (I (we)) lost saw the deceased alive on 9-9-1987 , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above. (I (we)) did (did not) view the body after death.							
22b. SIGNATURE Stephen W. Dejter, M.D.				DEGREE M.D.		22c. DATE SIGNED Oct. 09, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen W. Dejter, MD				22e. ADDRESS 6719 Wilson Lane Bethesda, Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 14 1987			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

086380-1371

100-41730

68078 OCT-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Geraldine M. Unterkoefler			2a DATE OF DEATH MONTH DAY YEAR 10 01 87			2b HOUR 6:40 PM				
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 09 16 19		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH montgomery County MD				
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse-Physicians Office		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Prince Georges		13c CITY OR TOWN Hyattsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 6500 Riggs Road	
14 FATHER'S NAME FIRST MIDDLE LAST J. R. Minshew			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leora Ann Copeland							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 553-16-3272		17 INFORMANT Same as Above 13E Gerald Unterkoefler (Son)						
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Rheumatoid Arthritis</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (1) (this hospital) attended the deceased from 7/27 1987 to 10/1 1987 that (1) (we) last saw the deceased on 10/1/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) sign the death certificate.										
22b SIGNATURE Myron L. Leuker				DEGREE		22c DATE SIGNED 10/3/87				
22d PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LEUKER				22e ADDRESS 2309 SHOREVIEW RD WHEATON MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10/3/87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alex. Va.		23d LOCATION (CITY OR TOWN COUNTY STATE)				
24 FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.				25a DATE REC'D BY REGISTRAR OCT 06 1987		25b REGISTRAR'S SIGNATURE Frederick Landess				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

068234 OCT 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vianne — Vanek			2a DATE OF DEATH MONTH DAY YEAR 10 1 87		2b HOUR 1952 M
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR MARCH 2, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH GAITHERSBURG	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY/CLERK		12b KIND OF BUSINESS OR INDUSTRY BRAC
13a STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN GAITHERSBURG	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Roy — SHOCKLEY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ALICE BOYCE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE		16b SOCIAL SECURITY NO 348-20-9827		17 INFORMANT KEVAN J. VANEK (S-N) P.O. Box 7922 HAMPTON, VA.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from March 19 87 to 10/1 19 87 that (I) (they) last saw the deceased alive on 10/1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE [Signature]		DEGREE MD		22c DATE SIGNED 10/4/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman		22e ADDRESS 19261 Montgomery Vill Ave, Gaithersburg			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b DATE OCT. 4, 1987	23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG CO. MARYLAND	
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS SILVER SPRING, MD.		25a DATE REC'D BY REGISTRAR OCT 8 1987	
				25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

1. The first part of the report is a summary of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

2. The second part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

3. The third part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

4. The fourth part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

5. The fifth part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

6. The sixth part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The work done on the project during the last year.
- (b) The results of the work done during the last year.
- (c) The conclusions drawn from the work done during the last year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward complete pages 1, 2, and 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

#548 per FAM. 1/4/88 Ken

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Willem		MIDDLE Baron		LAST VanHeeckeren		2a. DATE OF DEATH MONTH 10 DAY 06 YEAR 87		2b. HOUR 3:40 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 3 DAY 6 YEAR 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77-76 YRS.		7. IF UNDER 1 YEAR MONTHS 7 DAYS 11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Netherlands		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Civil Industry	
13a. STATE -8115 Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8115 Riverside Ave. 20818	
14. FATHER'S NAME FIRST DANIEL MIDDLE WIGLOD LAST WIGLOD				15. MOTHER'S MAIDEN NAME FIRST UNK. MIDDLE UNK. LAST UNK.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK.		16b. SOCIAL SECURITY NO. 100-22-9305		17. INFORMANT ADDRESS JOHANNA VAN HEECKEREN - wife 8115 RIVERSIDE AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's Disease - Severe								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 2 week 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Urinary tract infection Mesenteric Thromboses									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Sept 19, 1987 to Oct 6, 1987 that (2) (we) last saw the deceased alive on Oct 6, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE Lee R. Pennington, MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lee R. Pennington, M.D.				22e. ADDRESS 8218 Wisconsin Avenue, Bethesda, Md. 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME State Anatomy Board ADDRESS Balto., Md.									

OCT 09 1987 *Jicha Davidson-Randall*

08826 OCT 16 1981

068547 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine Van Meurs			2a. DATE OF DEATH MONTH 10 DAY 7 YEAR 87		2b. HOUR 6:30 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 8 DAY 24 YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Netherlands	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Fed. Govt.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Pr. Georges	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6700 Belcrest Rd. #716 20782	
14. FATHER'S NAME (FIRST MIDDLE LAST) Herbert Van Meurs		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Jacoba Vander Weyden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, UNKNOWN) Yes (IF YES, GIVE DATES) WWII		16b. SOCIAL SECURITY NO. 381-16-8434		17. INFORMANT ADDRESS Eleanore R. Klitzke-Glenwood, 3125 Rt. 97, Md. 21738	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF: (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 10 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Motor neuropathy					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I, OR PART II)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/4/87 , 19 87 , to 10/7/87 , 19 87 that (I) (we) last saw the deceased alive on 10/1/87 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If last I did not view the body after death.)					
22b. SIGNATURE H. C. Scruggs		DEGREE		22c. DATE SIGNED 10/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRUGGS MD		22e. ADDRESS 5413 Cedar Ln. Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-8-1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Alexandria Virginia		23e. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23f. LOCATION (CITY OR TOWN) COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 11800 N. H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR OCT 13 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the completed pages, 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100245 OCT 14 03

301 Russell Ave. 60604

Vander Vender - Jacobs

100245 OCT 14 03

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7 0575 124-387

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ralph Anton Varone			2a DATE OF DEATH MONTH DAY YEAR October 28, 1987			2b HOUR 8:45pm			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 565 Summit Hall Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer RCA		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13e STREET ADDRESS / ZIP CODE 565 Summit Hall Road/20877			
14 FATHER'S NAME FIRST MIDDLE LAST Pasquale Varone					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Marino				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 336 03 1923		17 INFORMANT Wife Vera S. Varone		ADDRESS Same as item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTRIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>10/1</u> 19 <u>86</u> to <u>10/15</u> 19 <u>87</u> , that (2) I saw the deceased alive on <u>10/1</u> and that in my opinion death occurred on the date and hour and from the causes stated above.									
22b SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED October 29, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Ralph Boccia M.D.				22e ADDRESS 14800 Physicians Lane #232 Rockville, Maryland 20850					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE October 31, 1987		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville/Montgomery/Maryland			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. ADDRESS 300 West Montgomery Avenue Rockville, Maryland				25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

10-1-25

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FAYE S. VAUGHN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 7, 1987		2b. HOUR 6:15P M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 9 1891		
6 AGE (IN YEARS (LAST BIRTHDAY)) 96 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		10 CITY OR TOWN OF DEATH BETHESDA		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY U.S. GENERAL ACCT. OFFICE		
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WASHINGTON, DC		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3022 PORTER STREET, NW 20008		13f. CITY OR TOWN SILVER SPRING, MD		
14 FATHER'S NAME FIRST MIDDLE LAST ISAAC NEWTON STANFORD		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH MARGARET CROWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 579-60-1516		17 INFORMANT SISTER CHARLENE KLINE		ADDRESS 611 DALE DRIVE SILVER SPRING, MD 20910		
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corticosteroid</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from <u>9/2</u> 19 <u>87</u> to <u>10/7</u> 19 <u>87</u> that (1) <u>last</u> saw the deceased alive on <u>9/2</u> 19 <u>87</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (If <u>not</u> <u>view</u> the body after death)						
23. SIGNATURE <u>Dr. J. Blaine Fitzjerald</u> MD				24. DATE SIGNED 10/8/87		
25. PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. BLAINE FITZJERALD				26. ADDRESS 8218 WISCONSIN AVENUE #408 BETHESDA, MD		
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		27b. DATE OCT10,1987		27c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		
27d. LOCATION CITY OR TOWN COUNTY STATE CLAY CITY CLAY ILLINOIS		28. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				
29a. DATE REC'D. BY REGISTRAR OCT 13 1987				29b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodden</u>		

088200 OCT 14 67

COX CO. OUT. KILLER

OCT 13 1967

069269 OCT 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Nhu K Vu			2a DATE OF DEATH MONTH DAY YEAR Oct. 18, 1987			2b HOUR P 12:55	
3 SEX Female		4 RACE Vietnamese		5 DATE OF BIRTH MONTH DAY YEAR July 21 1903		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vietnam		7b CITIZEN OF WHAT COUNTRY? Pern. Resident		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4114 Peppertree Lane				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a STATE Md.				13b COUNTY Mont.		13c CITY OR TOWN S.S.	
14 FATHER'S NAME FIRST MIDDLE LAST Lap C Vu				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thanh H. Pham			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 568 32 2669		17 INFORMANT ADDRESS Huong T. Pham (Daughter) Same as 13E			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) <u>ATHEROSCLEROSIS</u> stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERLIPIDEMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>Pituitary Deficiency</u>			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE		21g HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a I certify that (1) this hospital attended the deceased from <u>June 12, 1976</u> to <u>OCT 18, 1987</u> that (1) <u>was</u> lost saw the deceased alive on <u>OCT 18, 1987</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. I <u>viewed</u> <u>did not</u> view the body after death.			
22b SIGNATURE <u>Edward J. Richards MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c DATE SIGNED <u>10-18-87</u>		22d PHYSICIAN'S NAME (TYPE OR PRINT) Edward J. Richards, MD	
22e ADDRESS 10301 Georgia Ave. Silver Spring, Md			

23a BURIAL, CREMATION, REMOVAL SPECIFIC Burial		23b DATE 10/24/87		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.				25a DATE REC'D. BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE <u>James Davidson</u>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NOV 24 1964

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



3004 POLKOVN. 190E

NOV 24 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN VYSKOCIL		2a DATE OF DEATH MONTH DAY YEAR OCTOBER 17, 1987		2b HOUR MIN. 11:35A	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR January 1, 1900	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville	
14 FATHER'S NAME FIRST MIDDLE LAST August Mallanda		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Eichorn		16 STREET ADDRESS / ZIP CODE 4736 Powder House Dr. / 20853	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 121-01-2705		17 INFORMANT ADDRESS Thomas Vyskocil, same as #13	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADVANCED RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Emphysema Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (d) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (1) (the hospital) attended the deceased from January 1, 1986 to Oct 17, 1987 that I last saw the deceased above 1987 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (If I cannot, I did not, view the body after death.)					
22a SIGNATURE Thomas E. Dooley, MD		22b ADDRESS 17904 Georgia Ave., Olney, MD. 20832		22c DATE SIGNED Oct 17, 1987	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 21, 1987		23c NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Middle Village, Queens, NY		24 FUNERAL DIRECTOR A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814			
25a DATE RECEIVED BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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Handwritten notes and diagrams, including a large 'X' and various scribbles.

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Handwritten text, possibly a signature or name, appearing as a large, stylized 'X' or 'A'.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	7b. HOUR M
CLARA				WAGNER.	10-2-87	5:45 P
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	3-17-1896		91 YRS.		
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
POLAND	U.S.A.			MONTGOMERY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Hebrew Home of Greater Washington		Homemaker		Home	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery	Rockville		6121 Montrose Road (20852)	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Luzer Schachter			(UNOBTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO		106-26-1607		Laurel, Md. 20708 Leonard Wagner; Son; 123-28 Shadetree Lane;		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure Chronic</u> <u>6 months</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular disease</u> <u>years</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from <u>1-5-81</u> to <u>10-2-87</u> that (b) (we) last saw the deceased alive on <u>10-2-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Loretto S. Albioc</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-2-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LORETO S. ALBIOC</u>				22e. ADDRESS <u>6121 MONTROSE RD.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/4/87	Beth David Cemetery		Elmont, L.I., New York	
24. FUNERAL DIRECTOR'S NAME <u>DANZANSKY-GOLDBERG, MEMORIAL CHAPELS</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 05 1987</u>		
1170 Rockville Pike; Rockville, Md. 20852				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial preparation. (Important: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

068017 OCT-60

OCT 30 1960

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WINFRED F WALKER			2a. DATE OF DEATH MONTH DAY YEAR 10-27-87		2b. HOUR 5:10 A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 23, 1922		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 65	
7a. BIRTHPLACE (COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LOCKMAKER		12b. KIND OF BUSINESS OR INDUSTRY US POSTAL SERV
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MITCHIE WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA L. WOODS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES YES 1942-1945		16b. SOCIAL SECURITY NO 578-22-5820		17. INFORMANT ADDRESS MAE F. WALKER/WIFE/SAME AS 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)	
22a. I certify that (1) this hospital attended the deceased from January 1980 to Oct 27 1987 that (2) we last saw the deceased alive on Oct 24 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) did/did not view the body after death.					
22b. SIGNATURE Michael M. Dolan MD		DEGREE MD		22c. DATE SIGNED 10-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael M. Dolan MD		22e. ADDRESS B975 Conn. Ave Silver Spring MD 2094			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT 30, 1987		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	
23d. LOCATION (CITY OR TOWN COUNTY STATE) ROCKVILLE MONTGOMERY MARYLAND					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR NOV 2 1987		25b. REGISTRAR'S SIGNATURE Davidson-Randall	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS 501 WEST MONROE ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, at the time of the event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>JAMES L. WALTHALL, JR.</u>		2a DATE OF DEATH MONTH <u>10</u> DAY <u>13</u> YEAR <u>87</u>		2b HOUR <u>6:30</u> A.M.	
3 SEX <u>MALE</u>	4 RACE <u>White</u>	5 DATE OF BIRTH MONTH <u>10</u> DAY <u>2</u> YEAR <u>24</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>	7b CITIZEN OF WHAT COUNTRY? <u>United States</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD	
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Mechanical Engineer</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Navy Department</u>
13a STATE <u>Maryland</u>		13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Silver Spring</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <u>James</u> MIDDLE <u>L.</u> LAST <u>Walthall, Sr.</u>		15 MOTHER'S MAIDEN NAME FIRST <u>Edith</u> MIDDLE <u></u> LAST <u>Crockett</u>		13e STREET ADDRESS / ZIP CODE <u>11807 Renick Lane / 20904</u>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b SOCIAL SECURITY NO. <u>231-12-8195</u>		17 INFORMANT <u>Mary P. Walthall, Same as 13</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram negative bacterial sepsis + shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myasthenia Gravis with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myasthenic Crisis</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>11</u> <u>10/13</u> <u>87</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from <u>10/13</u> 19 <u>87</u> to <u>10/13</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>10/13</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) we did not move the body after death.					
22b SIGNATURE <u>Joel Goetz</u>		DEGREE		22c DATE SIGNED <u>10/13/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joel Goetz</u>		22e ADDRESS <u>4701 RANDOLPH ROAD ROCKVILLE MD</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b DATE <u>10-14-87</u>	23c NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria, Virginia</u>
24 FUNERAL DIRECTOR NAME <u>Richard Rapp, Inc.</u>		25a DATE REC'D. BY REGISTRAR <u>OCT 16 1987</u>		25b REGISTRAR'S SIGNATURE <u>Julia Sanders-Randall</u>	
P. O. Box 43352, Washington, DC 20010					

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068508 OCT 14 87

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG NO

 2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
 OCTOBER 7, 1987 9:10 P_M

 1 DECEASED NAME FIRST MIDDLE LAST
 PAUL ANTHONY WALZER

 3 SEX 4 RACE 5 DATE OF BIRTH 6 AGE (IN YEARS LAST BIRTHDAY) 7 UNDER 1 YEAR 8 UNDER 2 YEARS
 MALE C 1 APRIL 19 1910 77 YRS.

 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b CITIZEN OF WHAT COUNTRY? 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH
 MASSACHUSETTS USA MONTGOMERY MD

 10 CITY OR TOWN OF DEATH 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b KIND OF BUSINESS OR INDUSTRY
 SILVER SPRING 1708 LANSDOWNE WAY ESTIMATOR GOV'T PRINTING

 13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS / ZIP CODE
 MARYLAND MONTGOMERY SILVER SPRING YES ☐ NO ☐ 1708 LANSDOWNE WAY 20910

 14 FATHER'S NAME FIRST MIDDLE LAST 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
 JOSEPH WALZER ANNA HOFFMAN

 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b SOCIAL SECURITY NO 17 INFORMANT ADDRESS
 YES WWII 014-03-6758 VIRGINIA H. WALZER/WIFE/SAME AS 13

 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
 PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
 DUE TO, OR AS A CONSEQUENCE OF (b) 1st stroke
 Conditions, if any, which gave rise to immediate cause or stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hr
1 hr

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

 19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☐ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

 21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

 21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION (CITY OR TOWN) COUNTY STATE
 WHILE AT WORK ☐ NO WHILE AT WORK ☐

 22a I certify that (I) (this hospital) attended the deceased from 3/13/87 19 87 to 10/7/87 19 87 that (I) (we) last saw the deceased alive on 9/28/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

 22b PHYSICIAN'S NAME (TYPE OR PRINT) 22c ADDRESS 22d DATE SIGNED
 DR. LAVINE 9801 GEORGIA AVENUE SILVER SPRING, MD 10/8/87

 23a BURIAL, CREMATION, REMOVAL (SPECIFY) 23b DATE 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (CITY OR TOWN) COUNTY STATE
 BURIAL OCT10, 1987 WEST AUGUSTA CEMETERY W. AUGUSTA AUGUSTA VIRGINIA

 24 FUNERAL DIRECTOR NAME ADDRESS 25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE
 FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901 OCT 13 1987 Julia Davidson-Randall

BP

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO. 1 120-802380

071102 NOV-98

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BLANCHE WASSERMAN			2a DATE OF DEATH MONTH 10 DAY 30 YEAR 87 2b HOUR 6 P.		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH May DAY 9 YEAR 1905	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7b HOUR 6 P.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD		
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST Isadore MIDDLE Simkowitz LAST Betty		15. MOTHER'S MAIDEN NAME FIRST Betty MIDDLE (Unavailable) LAST (Unavailable)			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 056-07-7497	17 INFORMANT Gloria Cetron, Fairfax, VA 22031		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASPIRATION PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (c) MULTI-INFARCT DEMENTIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 10/15/87 to 10/30/87 that (1) (we) last saw the deceased alive on 10/30/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) did not view the body after death.					
22b SIGNATURE D.D. Patel		DEGREE M.D.		22c DATE SIGNED 10/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL		22e ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 11-2-87	23c NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Glendale, New York
24 FUNERAL DIRECTOR NAME Gramercy Chapels 152 2nd Avenue, New York, NY 10003			25a DATE REC'D. BY REGISTRAR NOV 06 1987 25b REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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068925 OCT 9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth M. Waters			2a. DATE OF DEATH MONTH DAY YEAR 10 11 87		2b. HOUR 10:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 21 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nutritionist		12b. KIND OF BUSINESS OR INDUSTRY Gov't,	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Waters		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Shipton		13e. STREET ADDRESS / ZIP CODE #427, 401 Russell Ave. 20877			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 033-28-9542		17. INFORMANT ADDRESS Robert D. Mariner, Jr. 608 McMagan Drive Pasadena, Md. 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5d. 5 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral thrombosis with hemiplegia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from Sept 5 19 87 to Oct 11 19 87 that (2) we last saw the deceased alive on Oct 11 19 87 and that in my opinion death occurred on the date and hour and from the causes stated above (3) we (did) (did not) view the body after death.							
22b. SIGNATURE James R. Moore, Jr.		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 207 Brookes Ave Gaithersburg Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Balt./Wash. Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.	
24. FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md.				25a. DATE RECD. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudolph	

DIVISION OF VITAL RECORDS, 701 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, complete, filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the completed page 3 and return it to the State Dept. of Health and Mental Hygiene prior to burial. Cremation, if desired, must be reported on page 23. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

008852 OCT 1981



20% COTTON FIBRE

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) FELTHAN WATSON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 26 1987		2b. HOUR 9:56 A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 20 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6016 CAIRN TERRACE 20817	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW H. WATSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Agnes Brennan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1964	17. INFORMANT ADDRESS JANET C. WATSON, 6016 CAIRN TERRACE, BETHESDA, MD			
18. CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 22 19 87 to OCTOBER 26 19 87 that (I) (we) last saw the deceased alive on OCTOBER 26 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Drew Lewis</i>		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 26 OCT 87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. LEWIS, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/29/87	23c. NAME OF CEMETERY OR CREMATORY Arlington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016			25a. DATE REC'D. BY REGISTRAR OCT 30 1987		
			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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NOT RECORDED

10/10/50

10/10/50

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MARKYARD U.S.A. *
Silver Spring Help Cross Hospital
Md. 7 Monte Alto
Robert F. Johnson
Rd. 1
Huntington, W. Va.

RECEIVED

CHRONIC

070092 OCT 29 1987

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

2a. DECEASED NAME FIRST MIDDLE LAST Josie B. Welch			2b. DATE OF DEATH MONTH DAY YEAR 10/25/87			2c. HOUR 5:52 P.M.			
3 SEX F		4 RACE CAUC		5 DATE OF BIRTH MONTH DAY YEAR 1 11 06		6 AGE (IN YEARS LAST BIRTHDAY) 81		7 IF UNDER 1 YEAR MONTHS DAYS YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Clerk		12b KIND OF BUSINESS OR INDUSTRY Medical School			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 540 Ednor Road 20904	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Wade Byrnes			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Poche			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) N/A			
16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A			17 INFORMANT Thomas F. Welch-son-Silver Spring, Md. 20904			18 ADDRESS 12701 Laurie Dr.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ATRIAL FIBRILLATION WITH CHRONIC CHF DUE TO, OR AS A CONSEQUENCE OF S/P ASPIRATION PNEUMONIA. (c) PARKINSON DISEASE S/P PSEUDO OBSTRUCTION OF INT									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NO <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Aug 19 87 to OCT 25 19 87 that I (we) last saw the deceased alive on OCT 25 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b SIGNATURE John E. Gledhill						DEGREE MD		22c DATE SIGNED 10/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John E. Gledhill						22e ADDRESS 733 Cloverway Ln. Silver Sp. Md 20904			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-28-1987		23c NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church Virginia		
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 14800 N.H. Ave. Silver Spring, Md.						25a DATE REC'D. BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE Julia Tindler-Rudner	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

70844 NOV-5

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30183

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frances White</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 30 87</i>			2b HOUR <i>11:26 PM</i>			
3 SEX <i>FEMALE</i>		4 RACE <i>CAUCASIAN</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>10/ 15/ 1897</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>90</i>		7 IF UNDER 1 YEAR MONTH DAY HOURS MIN <i>10 30 11 26</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>			
10 CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hosp</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			
13a STATE <i>MARYLAND</i>		13b COUNTY <i>MONTGOMERY</i>		13c CITY OR TOWN <i>POTOMAC</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>ISIAH LEAVITT</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ESSIE (UNKNOWN)</i>		13e STREET ADDRESS / ZIP CODE <i>8201 SNUG HILL LA. (20854)</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO <i>199-36-5930</i>		17 INFORMANT <i>SON</i> ADDRESS <i>MARYLAND 20854</i>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema - Death</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>myocardial infarction 2 days</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes mellitus, Hypertension</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>10/30</i> to <i>10/30</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>10/30</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) not view the body after death									
22b SIGNATURE <i>Barth...</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <i>10/30/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARBARA J. MORTIMER, MD.</i>				22e ADDRESS <i>8808 Proctor Ave L.A. - Potomac MD</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>11/1/87</i>		23c NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEM. PARK</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>PHILADELPHIA, PENNSYLVANIA</i>			
24 FUNERAL DIRECTOR'S NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>				24b ADDRESS <i>1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852</i>		25a DATE REC'D BY REGISTRAR <i>NOV 04 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Division-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's report must be attached.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) DELAINE ROY WHITMAN			2a DATE OF DEATH MONTH DAY YEAR 10 5 1987			2b HOUR 3:30 P.M.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 4 21 1934		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH CLARKSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15900 COMUS ROAD				12a USUAL OCCUPATION (WORK FOR MOST OF YEAR) GEOLOGICAL SURVEY / SCI. TECH. DIV.			
13a STATE W. VA.		13b COUNTY HARRISON		13c CITY OR TOWN MT. CLARE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS ROUTE 1 99999	
14 FATHER'S NAME FIRST MIDDLE LAST NEWMAN L WHITMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HINA F BAILES			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES 1956/1958			
16b SOCIAL SECURITY NO. 236-52-5459			17 INFORMANT J. DATHAN WHITMAN			ADDRESS RT 1 MT. CLARE W. VA.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GLIOBLASTOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx. 6 mo
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Leslie Paul - Frez, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/6/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Leslie PAUL - Frez, MD						22e ADDRESS 501 N. Frederick Ave, Catonsville, MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 10-10-87		23c NAME OF CEMETERY OR CREMATORY W. VA. MEMORIAL CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE CALVIN NICHOLAS W. VA.		
24 FUNERAL DIRECTOR NAME W.C. HILTON			24b ADDRESS 2211 BEALLSVILLE RD BARNESVILLE, MD.			25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE Julia Gordon-Parker	

DHMH 16 60M 1 73

(VRA 15 (4))

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodate in acidic solution. The methodology involves measuring the rate of reaction at different temperatures and using the Arrhenius equation to determine the activation energy.

2. The second part of the report is a detailed description of the experimental procedure. It includes the list of materials, the apparatus, and the steps of the experiment. The materials are hydrogen peroxide, potassium iodate, sulfuric acid, and sodium acetate. The apparatus includes a reaction flask, a thermometer, a stopper, and a gas syringe. The steps of the experiment are: (1) preparation of the reaction mixture, (2) measurement of the rate of reaction, and (3) determination of the activation energy.

3. The third part of the report is a discussion of the results. It includes a table of the experimental data, a graph of the rate of reaction versus temperature, and a calculation of the activation energy. The table shows that the rate of reaction increases with increasing temperature. The graph shows a linear relationship between the logarithm of the rate of reaction and the reciprocal of the absolute temperature. The activation energy is calculated to be 50.2 kJ/mol.

4. The fourth part of the report is a conclusion. It summarizes the findings of the experiment and discusses their significance. The findings show that the rate of reaction of hydrogen peroxide with potassium iodate is strongly dependent on temperature. The significance of the findings is that they provide a method for determining the activation energy of a reaction.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE) FIRST MIDDLE LAST WILLIAM JAMES Widmayer			2a DATE OF DEATH MONTH DAY YEAR 10 / 10 / 87		2b HOUR 5:25 A
3 SEX M ALE	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5 / 01 / 17	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACT SPEC	12b KIND OF BUSINESS OR INDUSTRY US GOVERNMENT	
13a STATE MARYLAND			13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHN WIDMAYER			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY AGNES SHEID		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO WWII 216-44-3225	17 INFORMANT ADDRESS IRENE K. WIDMAYER/WIFE/SAME AS 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 1)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (U) (this hospital) attended the deceased from 10/8/87, 1987, to 10/10/87, 1987 that (U) (we) lost saw the deceased alive on 10/9/87, 1987, and that in (U) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>[Signature]</i>		DEGREE		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner		22e ADDRESS 4701 Randolph Rd Rock Hill, MD 20852			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE OCT13,1987	23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a DATE REC'D BY REGISTRAR OCT 14 1987		

3
069453 OCT 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST
AGNES NANCEY WIDMEYER

2a DATE OF DEATH MONTH DAY YEAR
10/13/87

2b HOUR
6:50 AM

3 SEX
FEMALE

4 RACE
Caucasian

5 DATE OF BIRTH MONTH DAY YEAR
02/07/14

6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania

7b CITIZEN OF WHAT COUNTRY?
USA

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD

10 CITY OR TOWN OF DEATH
TOKOMA PARK

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST

12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE VA. 13b COUNTY Shenandoah 13c CITY OR TOWN QUICKSBURG 13d INSIDE CITY LIMITS? YES ☐ NO ☐ 13e STREET ADDRESS / ZIP CODE ROUTE 1 Box 161-B 22009

14 FATHER'S NAME FIRST MIDDLE LAST
Harry G. Buchanan

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Kattenbaugh

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN

16b SOCIAL SECURITY NO.
578-18-0219

17 INFORMANT ADDRESS
Robert B. Widmeyer/Rt 1, Bx 161-B, Virginia Quickburg

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last:
(c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☒ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from Oct 9 1987 to Oct 13 1987, that I (we) last saw the deceased alive on above, (I/we) (did) (did not) view the body after death.

22b SIGNATURE Martin O. Heitz DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED 10/13/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)
Martin O. Heitz 22e ADDRESS
7025 Greenway Ctr One Greenbelt MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b DATE
Oct 17, 1987

23c NAME OF CEMETERY OR CREMATORY
Solomon Luth. Ch. Cem.

23d LOCATION CITY OR TOWN COUNTY STATE
Quicksburg Shenandoah Va

24 FUNERAL DIRECTOR NAME
Dellinger F.H. S. Main St., Mt. Jackson, Va

25a DATE REC'D BY REGISTRAR
OCT 21 1987

25b REGISTRAR'S SIGNATURE
Davidson

BP
DHMH 16 60M 7/84
(VA 15, 4)

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100. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BETTY Nock WILD			2a. DATE OF DEATH MONTH DAY YEAR 10 / 22 / 87		2b. HOUR MIN. 5:15 P.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 60	IF UNDER 1 YEAR IF UNDER 24 HR. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Assistant		12b. KIND OF BUSINESS OR OCCUPATION (If not in business, give occupation) National Inst. Drug Abuse (Dhs)
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4706 Wyaconda Road Rockville, Md. 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Claude Stewart Nock		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 224-30-3574		17. INFORMANT ADDRESS Donald L. Wild (husband) same as 13e	
18. CAUSE OF DEATH: Enter one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (b) MALIGNANT LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c) SEIZURE DISORDER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTH. 10 DAYS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/12 19 87 to 10/22 19 87 that (I) (we) last saw the deceased alive on 10/22 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.					
22b. SIGNATURE Alan Diamond		DEGREE MD		22c. DATE SIGNED 10/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN DIAMOND		22e. ADDRESS 1106 SPRING ST SILVER SPRING MD			
23a. BURIAL, CREMATION, REMOVAL (EXCEPT) Burial		23b. DATE 10/26/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION (CITY OR TOWN) Rockville, Maryland		23e. STATE Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D BY REGISTRAR OCT 30 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Pudney					

07012 IN-51

10/22/77 5:15P

Rock Creek

Location	Time	Notes
Rock Creek	5:15P	Start of trip
Rock Creek	5:30P	Arrived at camp
Rock Creek	6:00P	Set up tent
Rock Creek	6:30P	Had dinner
Rock Creek	7:00P	Went to bed
Rock Creek	7:30P	Woke up
Rock Creek	8:00P	Had breakfast
Rock Creek	8:30P	Went for walk
Rock Creek	9:00P	Returned to tent
Rock Creek	9:30P	Wrote in journal
Rock Creek	10:00P	Went to bed

10/23/77 5:15P

Rock Creek

10/24/77 5:15P

Rock Creek

10/25/77 5:15P

Rock Creek

10/26/77 5:15P

Rock Creek

10/27/77 5:15P

Rock Creek

10/28/77 5:15P

Rock Creek

10/29/77 5:15P

Rock Creek

10/30/77 5:15P

Rock Creek

10/31/77 5:15P

Rock Creek

OCT 30 1977

10/31/77 5:15P

Rock Creek

069127 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JESSE C. Wilder			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 14 1987		2b HOUR 1836 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 7 1905		
6 AGE (IN YEARS LAST BIRTHDAY) 82		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10 CITY OR TOWN OF DEATH Rockville		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor		12b KIND OF BUSINESS OR INDUSTRY School Board		
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		
14 FATHER'S NAME FIRST MIDDLE LAST James Wilder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Ferguson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO. 271-1818-48		17 INFORMANT Carlene Collins		ADDRESS Gaithersburg, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) ischemic heart disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS YEARS YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Peripheral vascular disease, Arteriosclerosis, poor nutrition, Arteriosclerosis						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from February 1987 to October 14 1987 that (I) (we) last saw the deceased alive on October 14 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE [Signature]		DEGREE PHYSICIAN		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOSE A. QUIROS MD		22e ADDRESS 4343 Montgomery Av. Bethesda MD 20814				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 17, 1987		23c NAME OF CEMETERY OR CREMATORY Seals Farm		
23d LOCATION CITY OR TOWN COUNTY STATE Etchison Montgomery Md.		24 FUNERAL DIRECTOR NAME ADDRESS Barber Funeral Home, Laytonsville, Md. 20879				
25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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COLON FILE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGIA M. WILLARD					2a DATE OF DEATH MONTH DAY YEAR 10-12-87			2b HOUR 0527 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 3-30-12		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPT.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. - NURSE		12b KIND OF BUSINESS OR INDUSTRY MEDICAL			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY MONTGOMERY 13c CITY OR TOWN TAKOMA PARK 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET ADDRESS / ZIP CODE 700 1/2 CHANEY DR. #5, 20912				
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE WILLARD				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA GIDLEY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-0610		17 INFORMANT SKIP BAKER		ADDRESS 235 THOMAS NELSON LA. WILLIAMSBURG, VA.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Hypotension and Arhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a Recently treated for Rheumatism									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 10/11/87 to 10/12/87 that (1) (we) last saw the deceased alive on 10/12/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE David Cromwell MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DAVID Cromwell MD				22e ADDRESS 831 University Blv. Silver Spring Md. 20903					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-12-1987		23c NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.			
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS SILVER SPRING, Md. 20910		25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE John Andrew Rindall	

STATE

NEW YORK

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF

THE

COMMISSIONERS

OF THE

LAND OFFICE

AND

OF THE

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

AND

OF THE

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret R. Willard</i>			2a. DATE OF DEATH MONTH DAY YEAR Oct. 24 1987		2b. HOUR 9:20AM M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 1 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Poolesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (19025 POWDER CIRCLE) 19025 Powder Circle		12a. USUAL OCCUPATION (IF WORKING AT TIME OF DEATH) Ret. Secretary	12b. KIND OF BUSINESS OR INDUSTRY DC Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 19025 Powder Circle 20837					
14. FATHER'S NAME FIRST MIDDLE LAST William J. Weber		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Batson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Jane Bupp-daughter- (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Primary Biliary Cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Pneumonia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>9-17</i> , 19 <i>87</i> , to <i>10-24</i> , 19 <i>87</i> , that (1) (we) last saw the deceased alive on <i>9-17</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James Brodsky</i>		DEGREE MD		22c. DATE SIGNED 10-24-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Brodsky MD</i>		22e. ADDRESS <i>4701 Willard Ave Chevy Chase MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-27-1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home 11800 N.H.Ave. S.S.		25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

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ANALYTICAL

QUANT

EXTRACT

070675 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Beverly Wilkinson			2a. DATE OF DEATH MONTH DAY YEAR 10/30/87		2b. HOUR 0420 M		
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 22 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Silver Spring MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John F. Burke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 602-20-7811	
17. INFORMANT Fred Wilkinson		18. ADDRESS 11035 Lockwood Drive		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 10 yrs		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (the hospital) attended the deceased from 12/3 to 10/30 1987, that (1) (we) last saw the deceased alive on 12/30 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE Alfred Munzer MD	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Munzer MD		22d. ADDRESS 7600 Carroll Avenue Terrene Park Ma		22e. DATE SIGNED 10/30/87		22f. DEGREE MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-31-87		23c. NAME OF CEMETERY OR CREMATORY Georgetown Medical School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR NAME Robert B. Moran		24b. ADDRESS 1661 Good Hope Road, SE		25a. DATE REC'D. BY REGISTRAR NOV 03 1987		25b. REGISTRAR'S SIGNATURE Julia D. Smith-Rodwell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jonathan G. Williams			2a. DATE OF DEATH MONTH DAY YEAR October 26, 1987		2b. HOUR MIN 5:55p M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05/20/1997		6. AGE (IN YEARS LAST BIRTHDAY) YRS 90	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY College Professor	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 410 Marshall Manor Drive 20904	
14. FATHER'S NAME FIRST MIDDLE LAST George Guest Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Rhoads		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Margaret K. Williams-wife (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiratic Pneuemon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) 2 weeks 3 weeks					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 10/26/87 to 26 Oct 87 that (1) (we) last saw the deceased alive on above (1) (we) did not view the body after death. 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE [Signature]		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Koller, MD		22e. ADDRESS 4000 Olney Laytonville Rd. Olney, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-31-1987	23c. NAME OF CEMETERY OR CREMATORY Woodside Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brinklow Montgomery Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			25a. DATE REC'D BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]

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069174 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30193

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Virginia Willoughby			2a. DATE OF DEATH MONTH DAY YEAR Sept. 30 1987		2b. HOUR 10:45p
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 25 1913		6. AGE (IN YEARS (LAST BIRTHDAY)) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HRS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3503 Thornapple Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	12b. KIND OF BUSINESS OR INDUSTRY Moving & Storage	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3503 Thornapple Street/20815	
14. FATHER'S NAME FIRST MIDDLE LAST Archibald -- Taylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva -- McCormick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) --- 219-48-9784		17. INFORMANT 20561 Neerwinder St. Linda McCracken, Germantown, MD 20874	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, generalized</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6'12" metast.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION 3/12/1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bladder		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>87</u> to <u>9/30</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. Luther Hall, M.D.</u>				22c. DATE SIGNED 10/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luther Hall				22e. ADDRESS 6000 Wisconsin Ave. Chevy Chase, Md. 20815	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD		24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016			
25a. DATE REC'D BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randner			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to be used as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

BP

088174 OCT 20 67

TO: DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, OCTOBER 19, 1967.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) ELIZABETH WILSON			2a DATE OF DEATH MONTH DAY YEAR 10 4 87		2b HOUR 1:25AM
3 SEX F-Emaile	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR 7 29 1910		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Prince Geo. Seabrook 13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Sam Crowder			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Flynn		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) N/A		16b SOCIAL SECURITY NO 579-05-5224	17 INFORMANT ADDRESS Seabrook William R. Wilson 6403 96th Ave. Md.		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Respiratory failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **metastatic base of tongue**

DUE TO, OR AS A CONSEQUENCE OF

(c) **squamous cell carcinoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 19 85	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (a) this hospital attended the deceased from 10/3 87 to 10/4 87 that (b) we last saw the deceased alive on 10/3 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Marion D. Wells		DEGREE MD	22c DATE SIGNED 10/4/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WELTZ		22e ADDRESS 7525 Greenway Cir On Greenbelt MD 20770	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-7-87	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24 FUNERAL DIRECTOR NAME Rendon/Hale Lanham		25a DATE REC'D BY REGISTRAR OCT 14 1987	
25b REGISTRAR'S SIGNATURE F.H. Lanham		25c ADDRESS F.H. Lanham, Md. 20706	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 84 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit certificate. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. No fee is charged for this certificate. If the death is due to natural causes, or removal of the body for burial, cremation, or other funeral home services, the medical examiner must be notified of the death.

IMPORTANT: If item 21 is marked or item 18 above is marked, the medical examiner must be notified of the death.

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Blank lined paper with two punch holes on the right side.

OCT 14 1961

069893 OCT 27 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30195

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert George Wilson			2a DATE OF DEATH MONTH DAY YEAR October 23, 1987		2b HOUR A 3:20 M						
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 5, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8750 Georgia Avenue, #508B				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Building Inspector			12b KIND OF BUSINESS OR INDUSTRY D. C. Government		
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8750 Georgia Avenue, #508B / 20910			
14 FATHER'S NAME FIRST MIDDLE LAST Arthur Wilson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unavailable)							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-16-4524		17 INFORMANT ADDRESS Gertrude L. Wilson, Same as 13							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Resp. Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca Bleeding</u>										4 min	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) IF WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>10:13</u> <u>8/21/87</u> to <u>October 23</u> <u>19 87</u> that (I) (we) last saw the deceased alive on <u>10/13</u> <u>19 87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)											
22b SIGNATURE <u>[Signature]</u>						DEGREE <u>M.D.</u>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-23-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Edgar H. Levin, M. D.						22e ADDRESS 9801 Georgia Avenue, #341 Silver Spring, MD 20902					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 10-23-87		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d LOCATION (CITY OR TOWN COUNTY STATE) Alexandria, Virginia			
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010						25a DATE REC'D. BY REGISTRAR OCT 26 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, Page 4, and file it for filing within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, notify injury, or other traumatic event, the medical examiner who has jurisdiction.

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068744 OCT 16 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Frances H Windsor			2a DATE OF DEATH MONTH 10 DAY 11 YEAR 87		2b HOUR 9:45 PM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH 10 DAY 18 YEAR 99		6 AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN
7a BIRTHPLACE (STATE OR FOREIGN) Salisbury Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingwood Nursing Home		12a USUAL OCCUPATION (WORK FOR MOST OF WORKING LIFE) TEACHER		12b KIND OF BUSINESS OR INDUSTRY Public School
13a STATE MD		13b COUNTY Montgomery	13c CITY OR TOWN Salisbury	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 234 Newton St. 21801
14 FATHER'S NAME FIRST James MIDDLE Harvey LAST Harvey		15 MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Mitchell		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO 219-36-5771		17 INFORMANT Kay Forsht		ADDRESS 15436 Pennington Dr. Gaithersburg Md	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebro Vascular Insufficiency					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) (this hospital) attended the deceased from 7-1 19 87 to 10-11 19 87 that (ii) last saw the deceased alive on 10-6 19 87 and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (i) two did (the two) view the body after death.					
22b SIGNATURE John Tauber		DEGREE MD		22c DATE SIGNED 10-11-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e ADDRESS 8218 Wisconsin Ave Bethesda			
23a BURIAL, CREMATION, REMOVAL (TYPE)	23b DATE 10/14/1987	23c NAME OF CEMETERY OR CREMATORY PARSONS Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Md.	
24 FUNERAL DIRECTOR NAME Baker & Bounds		ADDRESS Salisbury Md.		25a DATE REC'D. BY REGISTRAR OCT 15 1987	
				25b REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove continuing papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30197

REG. NO.

FOR STATE REGISTRAR 1-1587		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MARGARET Theresa WOODS		2a. DATE OF DEATH MONTH DAY YEAR 10 - 10 - 87		2b. HOUR 0005 M.	
3. SEX F		4. RACE C I		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVERTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist		12b. KIND OF BUSINESS OR INDUSTRY Safeway	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11401 COLUMBIA PIKE #D8 20904	
14. FATHER'S NAME FIRST MIDDLE LAST John Francis Woods		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie b Robinson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-50-8003		17. INFORMANT Anna Jane Woods Sister Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>exhaustion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Summer</u> 19 <u>85</u> to <u>Oct 10</u> 19 <u>87</u> that (I) (we) last saw the deceased alive and above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D. Haidak</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/10/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DJ. HAIDAK		22e. ADDRESS Clinton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		24b. ADDRESS 500 University Blvd., W. Silver Spring, Md. 20901		24c. DATE REC'D. BY REGISTRAR OCT 14 1987		24d. REGISTRAR'S SIGNATURE Julia Davidson-Rodale			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME

(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Herbert

Milton

Woodward

2a DATE KNOWN OF DEATH ESTI MATED ☒ 10 31 19 87 2b HOUR 0058 M

3 SEX

Male

4 RACE

Caucasian

5 DATE OF BIRTH

9 16 23

6 AGE (IN YEARS)

64 YRS.

IF UNDER 1 YR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

2c DATE PRONOUNCED DEAD

10 31 19 87 2d HOUR 0058 M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

United States

8 MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County, MD

10 CITY OR TOWN OF DEATH

Rockville

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Shady Grove Hosp.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Owner

12b KIND OF BUSINESS OR INDUSTRY

Service Station

13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

MD

13b COUNTY

Montgomery

13c CITY OR TOWN

Germanatown

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS

14660 Seneca Rd. / 20874

14 FATHER'S NAME

William

MIDDLE

Franklin

LAST

Woodward

15 MOTHER'S MAIDEN NAME

Estelle

MIDDLE

Rose

LAST

Galion

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO.

WWII

17 INFORMANT

212-20-8058

ADDRESS

Mrs. Eloise L. Woodward, Wife, Same as #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ACUTE

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COMOTION GIVEN IN PART I (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☐ NO ☒

21a EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

1 P.M. 10 30 1987

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

DEVELOPED SHORTNESS OF BREATH

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☒

AT WORK ☐ AT WORK ☒

21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)

Home

21f LOCATION

14660 SENECAR RD GERMANATOWN MONTG. CO. MD

22a I certify that I took charge of the remains described above, held on

Autopsy ☐

Inspection ☒

Inquiry ☒

and in my opinion

death resulted from

Natural causes ☒

Accident ☐

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL SIGNATURE

Francis C. Mable

TITLE (SPECIFY)

M.D. Dept

MEDICAL EXAMINER

DATE SIGNED

10/31/87

EXAMINER'S NAME (TYPE OR PRINT)

Francis C. Mable

ADDRESS

300 W. Montgomery Ave., Rockville, MD. 20850

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

November 4, 1987

23c NAME OF CEMETERY OR CREMATORY

Darnestown Presbyterian Church Cemetery

23d LOCATION

Darnestown

COUNTY

Maryland

24 FUNERAL DIRECTOR NAME

Robert A. Pumphrey Funeral Home/

Rockville, MD 300 W. Montgomery Ave., Rockville, MD. 20850

25a DATE REC'D. BY REGISTRAR

NOV 2 1987

25b REGISTRAR'S SIGNATURE

John Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. FINAL PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

M

480

480

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FLOYD DONALD WORD			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1987		2b. HOUR 11:45 ^A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20 1933	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YEAR MONTH DAY HOUR MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Corpsman	12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7820 Miller Fall Rd. 20855	
14. FATHER'S NAME FIRST MIDDLE LAST William Avery Word		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tommie Coffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea Vietnam 410-50-9346	17. INFORMANT ADDRESS Mrs. Judith Word, wife, same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic bladder cancer DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 4, 1987, to October 17, 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on October 17, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.			
22b. SIGNATURE Louis Unperman, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/18/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Unperman, M.D.		22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE October 22, 1987	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. ADDRESS 300 West Montgomery Avenue Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

OCT 26 1987

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BP

DHMH 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lester Leonard Yates</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>10 24 87</i>				2b. HOUR <i>15:12M</i>	
3 SEX <i>MALE</i>		4 RACE <i>CAUCASIAN</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>3 24 11</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD			
10 CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Side Educational Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BOARD OF ED</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE <i>MARYLAND</i>		13b COUNTY <i>MONTG</i>		13c CITY OR TOWN <i>DICKERSON</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>20842</i> <i>21930 BIG WOODS ROAD</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>HENRY J YATES</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LOUISIA LAFORCE</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES GIVE WAR OR DATES) <i>NO</i>		16b SOCIAL SECURITY NO. <i>227-18-3625</i>		17 INFORMANT <i>ANNE P. YATES</i> ADDRESS <i>21930 BIG WOODS RD DICKERSON MD</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Non Small Cell Lung Cancer</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3d</i> <i>6 wks.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <i>Aug 1st</i> 19 <i>87</i> to <i>October 24</i> 19 <i>87</i> that (2) I saw the deceased alive on <i>October 24</i> 19 <i>87</i> and that in (3) my (4) our opinion death occurred on the date and hour and from the causes stated above. (1) we (2) did not view the body after death.									
22b SIGNATURE <i>Jeffrey M. Crane MD</i>				DEGREE				22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>JEFFREY M. CRANE M.D.</i>				22e ADDRESS <i>Suite 271 Physicians Lane 14801 Rockville MD 20850</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>10-27-87</i>		23c NAME OF CEMETERY OR CREMATORY <i>REST HAVEN</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>FREDERICK FREDERICK MD</i>			
24 FUNERAL DIRECTOR <i>W.C. HILTON</i> <i>Barneville, MD</i>				25a DATE REC'D. BY REGISTRAR <i>UCT 29 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>			

070827 101-281

MEMO
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report with several paragraphs of text.]

068349 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30201

FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) FIRST AKA: Joyce Ziebell LAST BETTY JOYCE ZIEBELL		2a DATE OF DEATH MONTH DAY YEAR OCTOBER 5 1987		2b HOUR 12:10 A M	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 5 1933		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a BIRTHPLACE (COUNTRY) GEORGIA		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN CHEVY CHASE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST LEON YOUNG GRANBERRY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AVIE RICE		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 252-46-3718	
17 INFORMANT ADDRESS EARL L. ZIEBELL, 8741 SUSANNA LANE, CHEVY CHASE, MD 20815		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from AUGUST 25 19 87 to OCTOBER 5 19 87, that (I) (we) last saw the deceased alive on OCTOBER 5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE R. P. Dolan MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED OCT 8 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R. P. DOLAN, LT, MC, USNR				22e ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/9/87		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Arlington, VA	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a DATE REC'D BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

080318 OCT 13 67

1. The first of the three main components of the system is the input device, which is used to enter data into the system. This component is responsible for converting the physical input (such as a keypress or a mouse click) into a digital signal that can be processed by the system.

068503 OCT 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30202

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORA ZINS			2a DATE OF DEATH MONTH DAY YEAR 10 7 87			2b HOUR 2:10 P.M.			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 2 25 1984		6 AGE (IN YEARS LAST BIRTHDAY) 103 YRS		7 IF UNDER 1 YEAR MONTHS DATE HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH silver spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN SIL. SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1708 REPUBLIC RD.: 20902	
14 FATHER'S NAME FIRST MIDDLE LAST HARRIS BLOCK					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA KOSWITSKY				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17 INFORMATION ADDRESS DAUGHTER-IN-LAW MARYLAND 20814 ELEANOR ZINS: 7514 NEVIS RD.: BETHESDA					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) ATRIAL FIBRILLATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/19/87, 19 to 10/7/87, 1987 that (I) (we) last saw the deceased alive on 10/6/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE K. S. D. HADAK, MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/7/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) K. S. D. HADAK, MD		22e ADDRESS NEW HAMPSHIRE AVE #212 CANDLEY PARK, MD 20763					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10/9/87		23c NAME OF CEMETERY OR CREMATORY MT. LEBANON		23d LOCATION CITY OR TOWN COUNTY STATE ADELPHI PG MARYLAND	
24 FUNERAL HOME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852				25 DATE REC'D. BY REGISTRAR OCT 13 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		Bertha B. Zlotnick				REG. NO. 30203			
2a DECEASED NAME (TYPE OR PRINT)						2b DATE OF DEATH		2c HOUR	
BERTHA B. ZLOTNICK						10 9 87		12 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
F Female		White C		1898 12 10 88		83 88 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MD BALTIMORE		USA				MONTGOMERY MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
S.S. Silver Spg.		CARRIAGE HILL NURS. CENTER				Homemaker		Home	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
MD		Mont.		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5480 WI Ave. # 1122 20815	
14 FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
ALFRED BERLINER		Selma ELIAS							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No		777-34-3448		Estelle B. Reiner Same as Item # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest Sudden									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease 20 years									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus; Generalized Arteriosclerosis									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from December 19 84 to 9 October 19 87 that (we) last saw the deceased alive on 9 October 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b SIGNATURE		DEGREE				22c DATE SIGNED			
John F. Gustafson, M.D.		M.D., ATTENDING PHYSICIAN				9 October 87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
John F. Gustafson, M.D.		5480 Wisconsin Avenue Chevy Chase MD 20815							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY STATE	
Burial		10/14/87		Ft. Lincoln Cem.		Brentwood, MD			
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
5130 WI Ave. NW Wash., DC 20016						OCT 16 1987		Julia Benson-Randall	

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Person H. H. H. H.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Noah Zuessman</i>		2. DATE OF DEATH MONTH DAY YEAR <i>10/2 2015 2:57 PM</i>	
3. SEX <i>MALE</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>01 27 07</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD</i>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Security Guard (Ret.) U.S. Gov't.</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>ICHIEL ZUESSMAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH GERSON</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO <i>578-07-0364</i>	
17. INFORMANT <i>Silver Spring, Md. 20902</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Severe Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>S/P volvulus</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-1</i> 19 <i>87</i> , to <i>10-3</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>10-2</i> 19 <i>87</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (If (we) (did) not view the body after death.			
22b. SIGNATURE <i>Loreto S. Albiol MD</i>		22c. DATE SIGNED <i>10-3-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LORETO S. ALBIOL</i>		22e. ADDRESS <i>6121 MONTROSE RD</i>	
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>10/6/87</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>D.C. Lodge Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> <i>1170 Rockville Pike; Rockville, Md. 20852</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 07 1987</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

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